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ABSTRACT

Three hearings held in Arizona, New Mexico, and South Dakota provide individual statements and panel presentations on problems, programs, and proposals for prevention, identification, treatment, and follow-up care of alcohol and drug abuse among American Indian juveniles. The majority of witnesses are members of Indian tribes in the three states--Apache, Navajo, Papago, Sioux, Ute, and Winnebago tribes among others. Other witnesses include directors and consultants for alcohol/drug abuse prevention and treatment programs and community health programs serving Indians, officers of the Indian Health Service, and superintendents of Indian schools. The 65 witnesses describe problems of alcoholism and drug abuse among children and youth on their reservations and discuss related problems of domestic violence, parental alcoholism, and teenage pregnancy. Witnesses explain existing prevention/treatment programs, discuss inadequacies of funding and political support for alcohol/drug education programs and treatment facilities, and present proposals for improving existing programs and establishing new ones. The appendix contains additional material submitted by 54 tribal governments, communities, schools, health services, prevention/treatment programs, and intertribal organizations. (LFL)

ED278525

INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

HEARINGS

BEFORE THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

ON

H.R. 1156

TO COORDINATE AND EXPAND SERVICES FOR THE PREVENTION, IDENTIFICATION, TREATMENT, AND FOLLOW-UP CARE OF ALCOHOL AND DRUG ABUSE AMONG INDIAN YOUTH, AND FOR OTHER PURPOSES

H.R. 2624

TO AUTHORIZE PROGRAMS FOR THE TREATMENT AND PREVENTION OF DRUG AND ALCOHOL ABUSE AMONG INDIAN JUVENILES

HEARINGS HELD

MAY 28, 1985, RAPID CITY, SD
JUNE 14, 1985, ALBUQUERQUE, NM
JUNE 15, 1985, PHOENIX, AZ

Serial No. 99-15
PART 1

Printed for the use of the
Committee on Interior and Insular Affairs

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INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

TUESDAY, MAY 28, 1985

House of Representatives,
Committee on Interior and Insular Affairs,
Rapid City, SD.

The committee met, pursuant to notice, at 8:15 a.m., in rooms 203-204, Rushmore Civic Center, Rapid City, SD; Hon. Sam Gejdenson, presiding.

Mr. **Gejdenson**. Thank you very much. As soon as we can get the technical end of this working, we will be in good shape. Thank you.

It is particularly appropriate that Tom Daschle invited us out here today. His concern for legislation affecting life of American Indians, has been exhibited throughout his entire time in Congress. And, at his suggestion, Chairman Udall, asked me to come out here. And, what we have done already, has been, I think, highly valuable to the committee staff that are here with us, and to myself. And, with that, I would like to give Tom an opportunity to make an opening statement.

Mr. **Daschle**. Thank you, Mr. Chairman.

I want to welcome all of our participants this morning. And, I especially want to express my appreciation to Chairman Sam Gejdenson, for taking the time out of an incredibly busy schedule this week, to come to South Dakota, for the first time, and to allow us to hold this hearing this morning.

I want to express my appreciation to the staff. To Debbie Broken Rope and Frank Ducheneaux, for the tremendous amount of work that they did in making ths hearing possible. And, of course, to the chairman, himself, for his interest in the issue, and for his willingness to allow, and to authorize, the hearing to be held at all.

The bill, H.R. 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act of 1985, in my opinion, is absolutely critical to the welfare of our Indian people.

I commend the leadership of this committee, both Republican and Democrat, for their showing the interest and the determination to solve this most serious problem among Indian people.

Chairman Mo Udall, and all the members of this committee, have demonstrated time and again, that the concerns of the Indian people are concerns that are deserving of bipartisan support.

There are, perhaps, no members of the committee, that have worked any harder or taken greater leadership in this whole role, than our colleague, Doug Bereuter.

Congressman Bereuter, is the prime sponsor of our bill. He had intended to be here this morning, but because of some scheduling difficulties in Nebraska, was unable to do so. But, certainly, his active efforts in sponsoring H.R. 1156, and his leadership in bringing this bill before the committee this morning, is very greatly appreciated.

Mr. Chairman, the problem of drug and alcohol abuse among the Indian people, has been well documented. While statistics over the years have changed in some areas, the problem of substance addiction has long been critical with Indian people.

The age adjusted mortality rates for Indians and Alaskan Natives, as compared to all races in the United States, is absolutely staggering.

According to the Indian Health Service statistics in 1976, the death rate per 100,000 people for all races in the United States, was 8.6. And, it was 7.5 percent in 1980. Yet, this compared to an incredible 69.8, 1976 rate, and a 41.3, 1980 rate, for the Indian/Alaskan Native population. Other statistics are equally graphic in describing the crisis and the proportion, in this problem.

Indian people have alcoholism rates at least seven times higher than the population of non-Indian people. At one South Dakota reservation, 95 percent of the reported arrests were alcohol related, with 89 percent of the prison incarcerations, and 90 percent of all hospital emergency room visits, directly attributable to drug and alcohol abuse. For some tribes, the fetal alcohol syndrome is seven times higher than the national average.

When presented with these staggering and indisputable figures, Representative Bereuter and I searched for a solution. We felt that perhaps, the most important role the Federal Government could play in combating this very serious problem, was through an effective education and counseling program, aimed at Indian youth.

A greater involvement for schools and the educational drug and alcohol educational process was envisioned, to target information to 40 percent of the Indian population, those who are under 18.

Investigation of the problem and available programs for Indian youth, revealed a startling degree of neglect. Out of the nearly 200 Indian Health Service alcohol treatment centers, at most, only two address the needs of Indian youth with respect to alcohol and drug abuse.

This serious educational and counseling void led to the introduction of legislation in the 98th Congress, which would have established the framework for such an educational process. H.R. 6196, was widely circulated among the Indian people, organizations and others involved, interested in seeing a solution to the critical problem. Suggestions were forthcoming from all across the Nation, many of which have been incorporated in this legislation.

The effort to combat the serious problem of drug and alcohol abuse of the Indian people, specifically the Indian youth, is long overdue.

This legislation represents a bipartisan attempt to engage the resources of the Federal Government, to work in a complementary fashion with tribal initiatives in this important area.

Comprehensive drug and alcohol programs will be required in reservation schools. Alternatives to incarceration are provided to those Indian youth arrested on drug and alcohol related charges. In addition, the use of existing facilities for the treatment and rehabilitation of alcohol and drug related problems, are incredibly important.

Mr. Chairman, I know I speak for all the witnesses today, and for the many, many people from throughout South Dakota, in thank you for your interest in this serious problem, and for bringing this important committee to our State, to hear directly, from those most adversely affected by the serious problem of alcohol and drug abuse.

For many involved in this serious problem, H.R. 1156 may be the only solution to the crisis. With your help, with the support of all the members in the Interior Committee, H.R. 1156, could become a reality. And I thank you for giving me this time. And I thank you again, for coming.

Mr. **Gejdenson**. Before proceeding to our first witness, and without objection, let us have printed at this point in the hearing, a copy of the bill, H.R. 1156.

[The bill, H.R. 1156, follows:]

I

99TH CONGRESS
1ST SESSION

H. R. 1156

To coordinate and expand services for the prevention, identification, treatment, and follow-up care of alcohol and drug abuse among Indian youth, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 20, 1985

Mr. BEREUTER (for himself, Mr. DASCHLE, Mr. UDALL, Mr. YOUNG of Alaska, and Mr. WILLIAMS) introduced the following bill; which was referred jointly to the Committees on Interior and Insular Affairs, Energy and Commerce, and Education and Labor

---

A BILL

To coordinate and expand services for the prevention, identification, treatment, and follow-up care of alcohol and drug abuse among Indian youth, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Juvenile Alcohol and Drug Abuse Prevention Act".

TITLE I—INTER-DEPARTMENTAL AGREEMENT

SEC. 101. (a) Within 90 days after the date of enactment of this Act, the Secretary of the Interior and the Secretary of Health and Human Services shall agree by means of a memorandum of agreement to—

(1) coordinate the Bureau of Indian Affairs and Indian Health Service alcohol and drug abuse programs existing on the date of enactment of this Act and programs established by this Act;

(2) identify Federal, State, local, and private resources to combat alcohol and drug abuse among Indians;

(3) delineate the responsibilities of the Bureau of Indian Affairs and the Indian Health Service to coordinate alcohol and drug abuse-related services at the central, area, agency, and service unit levels;

(4) determine the scope of the Indian juvenile alcohol and drug abuse problem and its estimated financial and human costs;

(5) authorize the Bureau of Indian Affairs agency superintendents and education superintendents and the Indian Health Service service unit directors to enter into agreements described in section 102; and

(6) provide for biannual review by the Secretary of the Interior and Secretary of Health and Human Services of the agreement under subsection (a).

(b)(1) The Secretary of the Interior and Secretary of Health and Human Services shall consult with and solicit the comments of interested Indian tribes and Indian individuals and Indian organizations in developing the agreement under subsection (a).

(2) The agreement under subsection (a) shall be submitted to Congress and published in the Federal Register within 90 days of the date of enactment of this Act.

SEC. 102. (a) At the request of any Indian tribe, the Bureau of Indian Affairs agency superintendent, the Bureau of Indian Affairs education superintendent, and the Indian Health Service service unit director for such tribe shall enter into an agreement with such tribe to coordinate resources and services related to alcohol and drug abuse prevention, identification, treatment, and follow-up care.

(b) Such agreement shall—

(1) identify the responsibilities and referral resources of all agencies and programs providing alcohol and drug abuse-related resources or services within such tribe's service area; and

(2) be modified semiannually to reflect changes in the availability of resources and services related to alcohol and drug abuse prevention, identification, education, treatment, and follow-up care.

SEC. 103. The Secretary of the Interior, acting through the Bureau of Indian Affairs, and the Secretary of Health and Human Services, acting through the Indian Health Service, shall bear equal responsibility for the implementation of this Act in cooperation with Indian tribes.

TITLE II—EDUCATION

Sec. 201. Section 304 of the Indian Elementary and Secondary School Assistance Act (20 U.S.C. 241cc) is amended by—

(1) striking out "and" at the end of paragraph (1);

(2) striking out the period at the end of paragraph (2) and inserting in lieu thereof "; and"; and

(3) adding at the end thereof the following new paragraph:

"(3) the training of counselors at schools eligible for funding under this title in counseling techniques relevant to alcohol and drug abuse .".

Sec. 202. Section 423 of the Indian Education Act (20 U.S.C. 3385b) is amended by adding at the end thereof the following new subsection:

"(e) 10 percent of the fellowships awarded under subsection (a) shall be awarded to persons who are receiving training in guidance counseling with a specialty in the area of alcohol and drug abuse counseling and education.".

Sec. 203. Section 315(a) of the Adult Education Act (20 U.S.C. 1211a(a)) is amended by—

(1) striking out the period at the end of paragraph (5) and inserting in lieu thereof "; and" ; and

(2) adding at the end thereof the following new paragraph:

"(6) to provide alcohol and drug abuse counseling services to better enable Indians in need of such services to take advantage of educational and employment opportunities.".

SEC. 204. (a) The Secretary of the Interior shall require Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination and Education Assistance Act (Public Law 93-638) to provide a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve.

(b) Schools providing programs of instruction under subsection (a) are encouraged to emphasize family participation in such instruction.

SEC. 205. (a) The Secretary of the Interior shall—

(1) establish summer recreation and counseling programs for Indian youth on reservations;

(2) require such Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination and Education Assistance Act as he determines to be necessary to remain open during the months of June, July, and August of each year to provide adequate facilities for such programs; and

(3) provide, as needed, salaried coordinators for such programs.

(b)(1) In addition to the facilities described in subsection (a)(2), the Secretary of the Interior is encouraged to use public facilities, other than those described in such subsection, and private facilities wherever possible for programs established under subsection (a)(1).

(2) Facilities which the Secretary may use under paragraph (1) shall be used under such terms and conditions as may be agreed upon by the Secretary and the authority having jurisdiction over any such facility.

(c) The Secretary of the Interior shall coordinate any programs established under subsection (a)(1) with any other summer programs for Indian youth.

SEC. 206. The Secretary of Interior shall, within 120 days of the date of the enactment of this title, publish an alcohol and drug abuse newsletter in cooperation with the Departments of Health and Human Services and Education to report on Indian alcohol and drug abuse projects and programs. The newsletter shall be published once in each calender quarter and shall be circulated without charge to schools, tribal offices, Bureau of Indian Affairs agency and area offices, Indian Health Service area and service unit offices, Indian Health Service alcohol programs, and other entities providing alcohol and drug abuse-related services or resources to Indian people.

TITLE III—FAMILY AND SOCIAL SERVICES

SEC. 301. (a) Any training program for community health representatives funded under the Act of November 2, 1921 (25 U.S.C. 13) shall include not less than two weeks of training on the problems of alcohol and drug abuse and shall include instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome.

(b)(1) The Director of the Indian Health Service shall, either directly or through contract, make available training on the problems of alcohol and drug abuse, including instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome to—

(A) the Bureau of Indian Affairs Superintendent of Education (or his designee);

(B) the Bureau of Indian Affairs Agency Superintendent (or his designee);

(C) Indian Health Service service unit directors;

(D) Bureau of Indian Affairs social workers;

(E) Indian Health Service doctors, nurses, nurse's aides, and paramedical personnel;

(F) Bureau of Indian Affairs school personnel;

(G) personnel of schools operated under contract under the Indian Self-Determination and Education Assistance Act; and

(H) supervisors of emergency shelters established under section 402(c) of this Act.

(2) The Director of the Indian Health Service shall also offer, upon request, the training described in paragraph (1) to—

(A) members of school boards governing—

(i) schools operated by the Bureau of Indian Affairs;

(ii) schools operated under contract with the Bureau of Indian Affairs; and

(iii) public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and California with significant numbers of Indian students;

(B) members of parent advisory committees of Bureau of Indian Affairs schools;

(C) members of child welfare protection committees serving Indian communities;

(D) educators at Tribal colleges which do not otherwise provide alcohol and drug abuse training to their personnel;

(E) Urban Indian Center counselors;

(F) home-school-liaison personnel funded under the Indian Elementary and Secondary School Assistance Act;

(G) Tribal Council members;

(H) Tribal court judges;

(I) Administrators of the Women, Infants and Children Program operated by the Department of Agriculture;

(J) personnel of public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and California with significant numbers of Indian students; and

(K) any interested member of the Indian community.

(c) The Secretary of Health and Human Services shall, upon request, provide certification to any person who completes training under this title for the purposes of obtaining academic credit or certification at any post-secondary educational institution.

TITLE IV—LAW ENFORCEMENT

SEC. 401. The Director of the Bureau of Indian Affairs shall, in the training of Bureau of Indian Affairs law enforcement personnel, provide education on the problems of alcohol and drug abuse among Indian juveniles.

SEC. 402. (a)(1) Subject to paragraphs (2) and (3), any tribal, Federal, or Bureau of Indian Affairs law enforcement officer who arrests an Indian juvenile for any offense related to the abuse of alcohol or drugs shall, in lieu of incarceration, place such juvenile in a temporary emergency shelter described in subsection (c) or a community-based alcohol or drug abuse treatment facility to the extent such facilities are available.

(2) Paragraph (1) and any regulation promulgated under paragraph (3) of this subsection shall not supersede any tribal law.

(3) The Secretary of the Interior, in consultation with the Attorney General of the United States, shall promulgate guidelines under which a law enforcement officer may place an Indian juvenile arrested for an offense related to the abuse of alcohol or drugs in a facility other than an emergency shelter described in subsection (c) for the benefit of the Indian juvenile or the safety of the community.

(b) In the case of any State which exercises criminal jurisdiction over any part of Indian country under section 1162 of title 18 of the United States Code or section 401 of the Act of April 11, 1968 (25 U.S.C. 1321), such State is urged to require its law enforcement officers to—

(1) place any Indian juvenile arrested for any offense related to the abuse of alcohol or drugs in a tem-

porary emergency shelter described in subsection (c) or a community-based alcohol or drug abuse treatment facility in lieu of incarceration to the extent such facilities are available; and

(2) observe the guidelines promulgated under subsection (a)(3).

(c)(1) The Director of the Bureau of Indian Affairs shall establish a program and approve a compensation schedule under which households of Indian families will be compensated to serve as temporary emergency shelters for Indian juveniles apprehended by any law enforcement officer for offenses related to the abuse of alcohol or drugs.

(2) No emergency shelter established under a program established under paragraph (1) shall commence operation until—

(A) the tribal council of any tribe to be served by such shelter approves such shelter; and

(B) such shelter meets the licensing requirements promulgated by the Bureau of Indian Affairs under paragraph (3).

(3)(A) The Bureau of Indian Affairs shall, within 120 days of the date of enactment of this paragraph, promulgate standards by which the emergency shelters established under a program under paragraph (1) shall become licensed.

(B) Such standards shall require that any individual supervising such shelter have completed the training described in section 301(b)(1) of this Act.

(4) The costs of construction of any emergency shelter are not authorized by this Act.

TITLE V—JUVENILE ALCOHOL AND DRUG ABUSE TREATMENT AND REHABILITATION

SEC. 501. The Director of the Indian Health Service shall, within 6 months of the date of enactment of this Act, conduct a study to determine—

(1) the size of the juvenile Indian population in need of residential alcohol and drug abuse treatment;

(2) where facilities to provide such treatment are or should be located; and

(3) the cost of providing such treatment.

SEC. 502. (a) The Director of the Indian Health Service shall provide a program of comprehensive alcohol and drug abuse treatment services, including detoxification and counseling services, and follow-up care in Indian Health Service facilities and in facilities operated under contract under the Indian Self-Determination and Education Assistance Act to Indian juveniles and adults in need of such services.

(b) No health facility described in subsection (a) shall be required under this section to provide inpatient services if such facility is primarily an outpatient facility.

(c) The Director shall report on the progress of the program provided under subsection (a) to relevant committees of the Congress within 18 months after the completion of the study described in section 501.

SEC. 503. (a)(1) The Secretary of Health and Human Services shall, in consultation with the Indian Health Service and the Bureau of Indian Affairs, identify and utilize wherever possible existing federally owned structures suitable for use as residential alcohol and drug abuse treatment centers for Indian juveniles to meet the needs identified in the study under section 501.

(2) Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary of Health and Human Services and the agency having responsibility for the structure.

(3) The Secretary of Health and Human Services may, directly or by contract, renovate any facility described in paragraph (1). Any such renovation shall conform with such terms and conditions as have been agreed upon under paragraph (2).

(b) The Secretary of Interior shall identify for the Secretary of Health and Human Services any existing Bureau of Indian Affairs facilities which could be utilized for residential alcohol and drug abuse treatment centers for Indian juveniles.

(c) If there is not an adequate number of facilities which may be renovated under subsection (a)(3) to meet the treatment needs identified in the study under section 501, the Secretary of Health and Human Services shall seek specific authority to construct such facilities as he finds necessary to meet such treatment needs.

TITLE VI—DEFINITIONS, EFFECTIVE DATE, AND AUTHORIZATION OF APPROPRIATIONS

SEC. 601. For the purposes of this Act, the term—

(1) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community of Indians, including any Alaskan Native village or regional or village corporation as defined in or established pursuant to the Alaska Claims Settlement Act (43 U.S.C. 1601, et seq.) which is recognized as eligible for special programs and services provided by the United States to Indians because of their status as Indians;

(2) "Indian" means any person who is a member of an Indian tribe;

(3) "juvenile" means any Indian under the age of 18;

(4) "service unit" means an administrative entity within the Indian Health Service serving one or more Indian tribes within a geographical area defined by regulation by the Indian Health Service;

(5) "service area" means the geographical area served by a service unit;

(6) "Indian Health Service area office" means an administrative entity within the Indian Health Service through which services and funds are provided to service units within a geographical area defined by regulation by the Indian Health Service;

(7) "Bureau of Indian Affairs area office" means an administrative entity within the Bureau of Indian Affairs through which funds and services are provided to agency offices within a geographical area defined by regulation by the Bureau of Indian Affairs; and

(8) "agency office" means an administrative entity within the Bureau of Indian Affairs serving one or more Indian tribes within a geographical area defined by regulation by the Bureau of Indian Affairs.

SEC. 602. (a) Except as provided in subsection (b), this Act shall become effective October 1, 1985.

(b) Titles I and VI and section 402(b)(3) of this Act shall become effective on the date of enactment of this Act.

SEC. 603. (a) There is authorized to be appropriated $5,000,000 to carry out the amendments in title II, the provisions of titles III and IV and the study in section 501 of this Act.

(b) There is authorized to be appropriated such sum as Congress determines to be necessary to carry out sections 502 and 503 of this Act after taking into consideration the findings of the study conducted pursuant to section 501.

○

Mr. GEJDENSON. Thank you. Without objection, we will place in the record, a statement by John McCain, Congressman from Arizona.

[EDITOR'S NOTE.—Prepared statement of Hon. John McCain may be found in appendix I. See table of contents for page number.]

Mr. GEJDENSON. We're going to call up the witnesses in a panel. If someone isn't here when we call them, we will call them again. We would just like to say, that with the reporter here, we will have all your written statements if you have them, placed in the record. And I think I always feel better just telling people what I think, rather than reading my statement.

[Prepared statement of Morgan Garreau may be found in appendix I.]

Mr. GEJDENSON. We can take your statement, put it in the record, and then, you can kind of make a summary of it. If you feel better reading it, read it. If you do not, just simply say what is on your mind.

We are going to bring the people up in panels. The first four to be brought up will be Mr. Newt Cummings, chairman of the Oglala Sioux Tribe, that was nice enough to give us hospitality yesterday, and show us around the reservation. Morgan Garreau, chairman of the Cheyenne River Sioux Tribe. Wallace Wells, Jr., chairman of the Crow Creek tribe. And, Mr. Michael Jandreau.

We would like to keep it somewhere around 5 minutes. We have a hard time sticking to that in Washington. We are certainly not going to keep an ironclad rule here.

Newt, you want to start?

Mr. CUMMINGS. OK. Thank you.

Mr. GEJDENSON. You know what, why not just give me a second here. Frank, maybe it makes more sense moving that box in front of him without ripping all the wires out. Now, those are recording mikes. That goes to the radio station and to the young lady over there, that keeps track of everything.

PANEL CONSISTING OF NEWTON CUMMINGS, CHAIRMAN, OGLALA SIOUX TRIBE FROM SOUTH DAKOTA; AND MORGAN GARREAU, CHAIRMAN, CHEYENNE RIVER SIOUX TRIBE FROM SOUTH DAKOTA

Mr. CUMMINGS. OK. Mr. Chairman, honorable congressmen, and members of the hearing panel. My name is Newton Cummings, and I am chairman of the Oglala Sioux Tribe in the Pine Ridge Indian Reservation; and, we offer you our hand in friendship, with a mutual understanding that we have a common enemy.

The common enemy I speak of has caused great hardship, injury, sickness, and death. The enemy I speak of has no respect for age; childhood, adolescence, as it affects the very young to the very old. The Dakota people suffer the most severe in negative statistics at the onslaught of the vicious enemy. This enemy is alcoholism.

We are here today in support of an enlightened weapon. A bill to be submitted before the U.S. Congress, H.R. 1156, to be known as the Indian Juvenile Alcohol and Drug Abuse Prevention Act.

It is with great anticipation, we support your efforts in the passage of this bill. The bill I address is prevention, identification and treatment of alcohol abuse and drug abuse among our young people. This bill is innovative for multiple purposes.

No. 1. It seeks a mandate, coordination and cooperation of agencies and resources such as the Bureau of Indian Affairs, and the Indian Health Service, upon tribal request.

No. 2. The bill focuses upon prevention, and this method is long overdue. The cliche of, an ounce of prevention is worth a pound of cure, is applicable, with the problem of alcohol and drug abuse among our youth. Perhaps a few, or many prevention cases is worth all hope, that by joining together, we can prevent progression of this disease and the devastating effect it has had on our people, the Oglala Sioux tribe.

Future generations need not suffer in consequences of alcohol abuse.

No. 3. The bills seeks expansion and improvement in the areas of education, law enforcement, family and social services, and Indian health service programs. All too many times, the existing programs have too little resources and lack of legislation, facilitating cooperation and coordination among agencies for such an enormous problem of alcohol and drug abuse, among our people.

No. 4. The legislation through title 2, amends the Indian Education Act, allowing funding for counseling of troubled youth, who are susceptible to, and have problems with alcohol and drug abuse. It also provides for specialized training in the needy areas of counseling, by providing fellowship for those persons pursuing a degree in counseling, and who specialize in alcohol and drug abuse.

No. 5. The bill addresses an area many of us have been concerned and have attempted to bring attention to, and, that is simply stated, our young people have little or no recreational facilities available to them. This bill requires an opening of Bureau of Indian Affairs school, for both recreational and counseling services, and we support this effort with addition, that this language include private, public, and parochial schools, located or near Indian reservations with Indian student enrollment.

No. 6. Title 3, establish programs in family and social services. This needs to be emphasized and expanded. Programs in crisis intervention and family counseling, are two of the most critical needed areas. Alcohol and drug abuse destroys every family and social fabric.

No. 7. Title 4 dealing with law enforcement is the best approach, for it provides training law enforcement personnel and alcohol and drug abuse situations, and also provides not only due process, but humane treatment of juvenile offenders.

Through this bill, a juvenile is detained in an emergency care facility, designated foster homes or community based treatment facilities, instead of the psychological scaring process of arrest and placement with adult offenders and prisoners.

The bill needs to emphasize the importance of providing appropriation for suitable detoxification and treatment facilities for trained personnel for the youth offender placements.

No. 8. The bill mandates both the Secretary of the Interior and the Indian Health Service, to monitor and provide updated study on a continuing basis. This is to insure, once the bill is passed, the problem is not pushed aside and forgotten. Hopefully, funds will be appropriated to insure continued study and monitoring of this problem, and make it a priority.

All too often, no data and information in specific terms, are available, leaving the impression that the problems of alcohol and drug abuse are secondary, when in reality, the problem is our number one health problem.

Congressmen and members of the hearing panel, we fully support your very worthy efforts in the introduction hearings and passage of the Indian Juvenile Alcohol Drug Abuse Prevention Act.

The intent, practical and innovative approached contained in this bill, are long overdue, and yet reflect an enlightened thinking beyond our generation. We support your efforts, yet, remain dubious that appropriations of $5 million which will include over 400 federally recognized tribes in Alaskan and native villages is sufficient. We feel the amount needed will have to be adjusted to reflect construction needs where no facilities exist. And, a commitment cost of providing continued prevention programs and specialized training staff and personnel with the necessary programs, where none, or few exist.

The authority needs to be inserted that there be annual appropriations made, with sufficient funding for a continuing year to year system in the initial amount, of $500 million, inclusive of construction costs for youth treatment centers and detoxification units. The amount, thereafter, would be substantially reduced, minus the initial construction cost.

Again, we support your efforts, and if you can be of any assistance to all, do not hesitate to ask for our support. Thank you on behalf of the Oglala Sioux Tribe.

And, also, Mr. Chairman, the Oglala Sioux Tribe supports the testimony of Project Phoenix, and the Little Wound school.

Mr. GEJDENSON. Thank you, Mr. Cummings. Could you identify youself and make a statement?

You might want to take that other mike and move it over a little, too.

Mr. GARREAU. Mr. Chairman, I am Morgan Garreau, chairman of the Cheyenne River Sioux Tribal Council. I appreciate this opportunity to testify on the proposed Indian Juvenile Alcohol and Drug Abuse Prevention Act.

Mr. Chairman, alcoholism is a problem that has plagued our people for generations. Sadly, the condition is one passed from parent to child. It would seem that the alcoholic parent almost inevitably leads to alcoholic children. This is due to physiological factors to some extent. The greater causes, however, seem to be social and psychological. If Indian alcoholism is to be controlled in our lifetime, the answer clearly is to avoid producing another generation of alcoholics. We must, therefore, devote every available resource to the prevention of alcohol and drug abuse among our young people.

To this end, the proposed bill represents a huge stride forward. By directing BIA and IHS to work together, the historic reluctance of BIA to involve itself in this most unhappy aspect of Indian life may be overcome. By requiring IHS to devote more resources to the problem, the bill will cause those resources to be applied to the single greatest health problem of Indian people today.

And by focusing on the prevention of alcoholism among young people, the most important resource of Indian tribes—our young people—will be allowed to reach their full potential, and lead our people beyond the poverty, ignorance and disease that we have suffered for so long.

Turning to the specific provisions of the bill, we support fully title I of the bill, which requires BIA and IHS to coordinate all available recources for the prevention of juvenile alcoholism.

We also support title II, which mandates that alcohol and drug abuse counseling be provided in Indian schools, and provides that currently available funds be devoted to the training and education of counselors, in the area of alcohol and drug abuse prevention.

We are concerned, however, about the provision requiring that 10 percent of the fellowships awarded under the Indian Education Act, go to persons receiving training in alcohol counseling. This amount, is at once, too much to take from other educational endeavors, and too little to provide funds for the number of alcoholism counselors needed in Indian country.

We recommend that a fellowship program be established and funded independent of the existing program.

We also are concerned about the provisions requiring 638 contract schools to offer programs of instruction on alcoholism. Our concern is not based upon disagreement with the concept but, rather, with the fiscal impact of such requirements on already strained school budgets. If additional funds are made available to these schools, of course, this concern is answered.

Title III of the bill deals with family and social services. We support the concept of making available training to government personnel on the matter of alcoholism. We believe, however, that such training should be mandatory for the Federal Government personnel listing in paragraph 301(b)(1).

We also support title IV of the bill. It is imperative that law enforcement personnel on Indian reservations, be trained adequately to deal with juvenile alcohol and drug abuse. We also appreciate the fact that the bill shows due deference to tribal law, while still authorizing alternatives to the incarceration of juvenile alcohol abusers.

Title V of the bill, touches upon an issue of great importance to my tribe. In 1980, the Cheyenne River Sioux Tribe, was sued in an effort to improve conditions at the tribal jail. In settlement of this claim, the tribe had to agree to make a number of improvements to the existing jail, which was built and is owned by BIA, and to provide a separate facility for the detention of juveniles.

Despite 4 years of effort, we have been unable to persuade the Bureau to make provision for the necessary reparis and construction.

Mr. Chairman, the tribe does not want to see delinquent children become adult criminals, nor do we wish to have tribal offenders jailed in unnecessarily poor facilities. Punishment is only one aspect of criminal justice.

Far more important aspects of criminal justice, are the rehabilitation and, where appropriate, treatment of offenders. We cannot provide a proper rehabilitation program to inmates when the facilities are in greater need of rehabilitation, than inmates. Equally important, we are unable to meet the court ordered standards imposed in the 1980 lawsuit.

We emphasize that if the tribe were not contracting the law enforcement program on the reservation, the BIA would have been the defendant in the 1980 lawsuit.

Although BIA is requesting $79 million in facilities, operation and maintenance funds for fiscal year 1986, our renovation and expansion of the detention facilities has received such a low priority, that no part of those millions is scheduled to be spent on the Cheyenne River jail.

Moreover, the Bureau makes no request for construction moneys. Thus, no funds for the construction of a juvenile detention facility will be forthcoming.

Mr. Chairman, we are left in an untenable situation. Under the Self-Determination Act, we contracted in good faith, to operate the Law Enforcement Program using BIA facilities. Those facilities are inadequate and unlawful. Yet, BIA refuses to upgrade its facilities.

If we are unable to force the Bureau to meet this request, we face a very difficult situation. One option open to us is to retrocede the law enforcement contract.

In fact, we have no intention of retroceding. We would note, however, that if Secretary Hodel and BIA officials were the defendants in the court proceedings, instead of tribal officials, funds for the necessary repairs and construction undoubtedly, would be found.

Much of the serious crime on our reservation, is alcohol-related, particularly among juveniles. We urge that a provision be included in this bill, requiring BIA to give the renovation, expansion and construction of juvenile detention facilities, top priority in future facilities maintenance funding allocations.

Mr. Chairman, again, I express my appreciation for this opportunity to testify before the committee.

Mr. **Gejdenson**. Thank you. I can tell you that Frank here, who is a member of your tribe, as you know, is on the full committee staff, and one of the key staff people.

And, I can assure that he keeps on top of me, as the chairman, to make sure the interests are kept at the forefront.

Mr. Daschle?

Mr. **Daschle**. Thank you, Mr. Chairman. In the interest of time I think we will try to limit our questions. But, I think it would be very helpful for the committee and, for the record, if you could just touch on three things very briefly.

Number one, what are the substances that are now most often used by youth in drug abuse and alcohol abuse? Secondly, what effect do you see it having on the children themselves from the personal experiences you have had?

Then, finally, what is the punishment right now? Reference was made yesterday during our site visit to the fact that juveniles are thrown right in with people far older than they are, and that that has had a real devastating consequence for some of these children.

Could you touch on those three things? Substance, effect, and punishment. Newton, could you start, and then Morgan can add.

Mr. **Cummings**. OK. I guess when we deal with substance, we have many different drugs and chemicals that our youth are inhaling, and toxic chemicals that they use. And, I know, for a couple of years, paint was a real bad substance that they were inhaling.

And, in effect, I have seen in several youth in my own area with damage to brain. And, these two gentlemen now are up in the twenties and thirties, but they, you know, have a mind of a child and that is one thing that is very damaging.

Mr. **Daschle**. So, they inhale paint.

Mr. **Cummings**. They inhale paint, spray paint.

Mr. **Daschle**. And, as a result, it caused brain damage and now they have——

Mr. **Cummings**. Right. Their mind is that of a child.

Mr. **Daschle**. Someone was saying yesterday, that the use of a common product like Lysol, is actually prevalent.

Could you elaborate on that?

Mr. **Cummings**. Well, I am not too familiar with that, but I do know it is moving into our area. A lot of our kids are starting to use Lysol. And, I understand that they take the spray type Lysol, and punch a hole in the can, and then they use a substance that gathers in the bottom which has a pretty high alcohol content in it.

Mr. **Daschle**. Now, is the effect of the use of these substances very obvious, early on, or does it take sometime before the actual effect can be seen visually?

Mr. **Cummings**. Well, with alcohol, I mean, with Lysol, I do not know just what those effects are. I have not been around it too much. With paint, it takes quite awhile before there is a reaction there, but it does really affect them. And, a lot of our young mothers and fathers that used paint, their children are also mentally retarded when they are born.

Mr. **Daschle**. So, there is a genetic problem associated——

Mr. **Cummings**. Right, a genetic problem.

Mr. **Daschle** [continuing]. With the use of these chemicals.

Talk just briefly if you would, about the punishment. What happens to them when they are incarcerated?

Mr. **Cummings**. Well, usually, when they are incarcerated, we try to take them away from their families and place them with other families, that is, if the families are also using the chemicals, or whatever, with their children, which happens in a lot of cases. The adults and the children use it together. So, we take the children and place them in a home, and try to provide counseling, the best we can, to the parents and to the children, and, hopefully, in time, we will get them back with their parents.

Mr. **Daschle**. So, it is rare that a 10- or 12-year-old would be put in prison?

Mr. **Cummings**. Oh, no; I do not think they would be put in prison. They may be detained in jail until, you know, a place is found for them to stay.

Mr. **Daschle**. A 10- or a 12-year-old could be put in jail?

Mr. **Cummings**. I think they could, right. According to our laws.

Mr. **Daschle**. Morgan, do you have anything to add to that?

Mr. **Garreau**. Well, I would just like to say based on the substance, some of the things that Newton has touched on, we also have things like marijuana. With regards to alcohol, it's either what you would call hard liquor, beer is prevalent on the reservation.

But, one of the other things that we have been having a problem with also is what they call liquid paper.

Mr. Daschle. Liquid paper?

Mr. Garreau. Yes. What some of the kids have been doing, is they take a plastic sack.

Mr. Daschle. You are talking about the little white bottles of——

Mr. Garreau. Yes, yes. What they will do is they put that in a sack, they break it, and they sniff that. I caught one of the youngsters in the tribal building in the restroom. We had to call the hospital so that they could take the child to the hospital. Eventually, as I understand, they flew the child off for treatment.

Mr. Daschle. What is their state when they take something like that?

Mr. Garreau. Well, the child that I found, once I caught him, he was sitting on the bathroom stool and he could not rise. He tried to get away, but he staggered and I had to help him to his feet. And, I helped him out and I took him into the office and called the hospital immediately because we could see that he was in serious condition.

And, they took him to the hospital and provided treatment. And, as I understand, they did fly him off for further treatment. But, that is one of the problems that we are having also with regards to marijuana, alcohol.

Some of the problems here, I have here something put together by a juvenile probation officer.

Mr. Daschle. Morgan, maybe you could speak up. I do not think they can hear you in the back there.

Mr. Garreau. Mr. Darrell Bow, he stated that 90 percent of the juveniles that are placed on probation, are alcohol and drug related incidents or offenses.

For the past 2 or 3 years, juvenile court records show that on average, one juvenile is arrested by police about every day and a half.

Mr. Daschle. Are you talking about just your reservation?

Mr. Garreau. Just my reservation, yes.

Mr. Daschle. Every day and a half, there's one——

Mr. Garreau. One juvenile arrested.

Mr. Daschle. And 90 percent of those arrests are alcohol related.

Mr. Garreau. Two out of every three arrested is alcohol related. The majority of all the crimes that are committed by the juveniles on the reservation are alcohol and drug related. So, we feel that we do have a problem on the reservation. That is why we are very supportive of the bill that you are cosponsoring. Thank you.

Mr. Cummings. One thing I might add. I do not know if I mentioned it, but we did add to our law and order code that drugs are now added into our code, which we never had before. It was mandatory to include drugs. We do punish them for it.

Mr. Gejdenson. Thank you, very much.

Newt, again, thank you for the hospitality yesterday.

Mr. Cummings. We thank you very much for coming down. It was a great experience and I think, a very productive meeting. And——

Mr. Gejdenson. Sure was.

Mr. **Cummings** [continuing]. We are happy to have you. Anytime you want to come back, you are welcome.

Mr. **Gejdenson**. Thank you.

Let me again call, and I am going to recall some of the names. Anybody that has shown up since I last called, feel free to come up and let me see if we can get four up here.

Wallace Wells, chairman of the Crow Creek Tribe. Michael Jandreau, chairman of the Lower Brule Tribe. Mr. Webster Two Hawk, chairman of the Rosebud Sioux Tribe. Mr. Richard Kitto, chairman of the Santee Tribe. Mr. Russell Hawkins, chairman of the Sisseton-Wahpeton Tribe. You give me Mohicans and Pequots, I can pronounce all those.

OK. Mr. Allen White Lightning, chairman. Mr. Richard LaFromboise, LaFromboy; you ought to see what people do to Gejdenson.

Ms. Jean Belille, We have—OK, terrific. I think I called up one too many. OK. That is better. Now we can see what is going on here. OK.

Now, let me again say, that you can put your written statements in the record. They will appear there for the committee. That if you want to just summarize your positions, that would be of great help.

Before you start, if you could, two things. One, this microphone to your right, is the microphone for the recorder, and that is important that it is near you when you are speaking. The one in the center, is the one that helps people hear, and that is also important for you to speak into.

Now, why not just go through and identify yourselves, first, starting over here.

Mr. **Miller**. Greg Miller, director of the Alcoholism Program at Lower Brule.

Mr. **Gejdenson**. OK.

Mr. **Jandreau**. I am Michael Jandreau, chairman of the Lower Brule Sioux Tribe.

Mr. **Gejdenson**. All right.

Mr. **Kitto**. I am Richard Kitto, the chairman of the Santee Sioux tribal council.

Mr. **Gejdenson**. All right.

Ms. **Poitra**. I am Barbara Poitra. I am representing Richard LaFromboise, chairman of the Turtle Mountain Tribe.

Mr. **Gejdenson**. OK. Terrific. Where are you going to start, right there?

Mr. **Jandreau**. I will let Greg go ahead and read through this, and then, I have a few observations I would like to make.

Mr. **Gejdenson**. Why not pull that microphone again, over as well. See that center one there. If you want to pull that. There we go. That will help you. Go right ahead.

[Prepared statements of Greg Miller, Richard Kitto, and Barbara Poitra, with attachments, may be found in appendix I.]

PANEL CONSISTING OF GREG MILLER, DIRECTOR, LOWER BRULE SIOUX TRIBE ALCOHOLISM PROGRAM FROM SOUTH DAKOTA; MICHAEL JANDREAU, CHAIRMAN, LOWER BRULE TRIBE FROM SOUTH DAKOTA; RICHARD KITTO, CHAIRMAN, SANTEE TRIBE FROM NEBRASKA; AND BARBARA POITRA, REPRESENTING TURTLE MOUNTAIN CHIPPEWA TRIBE FROM NORTH DAKOTA

Mr. **Miller**. Mr. Chairman, honorable Congressmen, and members of the hearing board, good morning.

My name is Greg Miller, and I am an alcoholic. I am also director of the Alcoholism Program of the Lower Brule Sioux Tribe, of Lower Brule, SD.

The Lower Brule Souix fully supports the intent in the various provisions of H.R. 1156, and urge its passage by the committee in the full House.

As may not be contestable, and may instead be well-known, the illness of alcoholism and the abuse of alcohol and other controlled substances, is a disease of pandemic proportions in Indian communities. There is not one family on most reservations in South Dakota, that is not in some way affected by this disease.

This disease and its destructive force, has for too long been ignored or minimized, by the service delivery systems in place. Administration after administration, Congress after Congress, and tribal governments have continued almost as if unconscious of the enormity of this disease. H.R. 1156 at long last recognizes the severity of the problem, and seeks, however halfheartedly, to address it.

If anything, the bill does not go half far enough. It adds education and interjurisdiction dimensions in delivering services to those affected by the illness. But $5 million seems hardly an adequate authorization to fully attend to the situation.

Somewhere in the bill, there could perhaps be added a provision to require Indian Health Service's epidemiology to include all alcohol and substance abuse relationships of illnesses reported.

Failure to do so, has consistently not provided information to decisionmakers, regarding the true cause of such health problems as trauma, caused by violence or accidents, diabetes, hypertension, heart failure and even, because of parent neglect, massive cases of upper respiratory infection and unnecessary dehydration or malnutrition, in children younger than five.

If the level of illness affecting Indian people today, in this country, was suffered by any other population group, national fund raising agencies would rush to find a cure.

Not $5,000, but billions of dollars would be raised annually, to identify causes, to isolate persons affected by the disease, from others who would certainly become infected by it.

Treatment regimens would be studied, restudied and made the object of Nobel prizes. In fact, the neglect shown this problem by the Government of the United States, will be judged by other nations and future generations, as a genocidal crime similar in proportion to the Nazi decimation of the Jews. So, while we applaud the bill, we decry the fact that it has taken so long for it to be proposed.

More particularly, as to the specific provisions of the bill, the memorandum of agreement mandated in section 101[a], must not be allowed to repeat the process of chasing a problem with paper, begun by the Merriam Report, and continued on through the generations, up until as recently as the seventies, when the same two agencies, Bureau of Indian Affairs and Indian Health Service, were required to act in a similar fashion in regard to the education of the handicapped.

Indeed, throughout the last 60 years, studies, reports, and other memoranda of agreement have continued to be written and the problem, like alcoholism and substance abuse, has continued to worsen year by year.

What has to be done, not at the highest level, but at the lowest level of government, is a development of service delivery systems that are based on client need and not agency, bureau or departmental regulations.

In title II, section 204, some direction should be provided local education agencies to intervene, when it becomes apparent, that a child is affected by alcohol or substance abuse.

Instruction without intervention tends at times, simply to raise the awareness of children of the variety of methods that remain for them to experiment with. Therefore, the schools must begin to understand their responsibilities to include outreach into family environments and aftercare situations, as well as in class instructional activities.

In title III, the act should also require education in the problem, as well as more and more effective treatment plans.

A major problem at the local level in dealing with alcohol and substance abuse, as also with other social pathologies, the chief deterrant to wellness has been the inclination of service providers to find another agency than themselves, whose responsibility it is to deal with a client's problem.

In title IV, the idea of developing temporary emergency shelters in community based facilities, could provide an excellent alternative to incarcerations which have not proved to be rehabilitative, but only if persons capable of showing tough love could be found to staff these centers.

In general, then, the tribe that I represent is much in favor of H.R. 1156, and, if anything, urges that it be strengthened by increasing the funding authorization and strengthening some of its provisions. Thank you for the opportunity to present this testimony.

Mr. **Gejdenson**. Thank you.

Identify yourself again, please?

Mr. **Jandreau**. Michael Jandreau, chairman, of the Lower Brule Tribe.

I guess you will see that by this testimony, we do support H.R. 1156, with reservation. Reservation, being that currently, there exists the procedures and the processes in both, the Indian Health Service, and the Bureau of Indian Affairs, to combat the problems that I identified, and to work with solutions.

If H.R. 1156 does not become law, what efforts will this committee take to bring about utilization of the current processes that are available, or, will they take any effort?

I guess the other thing I have to ask, very significantly. A great deal of why the problems are not being addressed, at this particular point in time, is because of the inability of the administrative structure to monitor the performance of the individuals they have, and the capacities to do the work.

What will this committee do to see that that happens?

There is a process that identifies what happens when someone does not perform their job. But, what is happening in relationship. That is all I have to say.

Mr. **Kitto.** Hon. Congressman Daschle, and committee members. I am proud to be here today. My name is Richard Kitto. I am the tribal council chairman of the Santee Tribe.

In hearing what a lot of the people are saying, is that we give almost 100-percent support to H.R. 1156. The only thing that we see and I imagine other tribes see also, is that there is a lot of administrative areas that have to be developed and worked on together between the Indian Health Service, the Bureau, and the tribes. That is one of the most important, you know, points that I see, that needs to be done.

At this point, it is going to be a unique situation because all of the tribes, you know, there are individual tribes. They all have different methodology of carrying out what the program wants, what they want for that program. So, I see that $5 million is a little bit of a boost to, you know. the area of Indian health service and drug abuse, and so forth. But, in the long run, I think that, you know, $5 million is pretty much a drop in the bucket. Hopefully, at sometime in the future, that that will be developed so there is more of a budget to work with than $5 million.

I think that one of the problems that Indian people have, especially with youth, with drug abuse and alcoholism, is that there are really no facilities where the youth themselves can identify with their peers in a positive setting, and also, in a negative setting.

The majority of the time, you have just the negative element, and this negative element is out running alone by itself, you know, therefore, it is in a situation where, you know, it grows more on the positive element of the youth. The positive peership. Pretty soon, the negative element of that peership is taken over on the positive element.

At some point in time, we need to have some measures of instilling, you know, some pride and some abilities, and looking at different types of programs for the youth. Some for the people who are in a positive area, and some who are in the negative peership area.

I just wanted to throw that in there. I do not have too much more, except that hopefully, in general, the bill is good and we are in support of it. But, at some point in the future, hopefully, the bill could bring about a lot more for the needs of the Indian people.

Mr. **Gejdenson.** I can just say to both of you, this is a beginning. It is not the end all that I think Congressman Daschle and myself, both would like to do a lot more. There are some realities in Washington, at the moment that we have to confront. I think that what this is, is the beginning of a process, not the end of it.

That whether this bill moves forward or not, and I am confident it will move forward, is that this is only the start and you are going to see a lot more.

Mr. KITTO. I have one other thing to add, Mr. Chairman. That we would like to add to our testimony, a supplemental, from what was formerly called Aberdeen Area Committee For Youth. Now, it is called United Tribes For Reservation Youth Committee, Inc. We do have a gentleman here who has that written testimony. So, shortly, he will bring it up to you, Deborah.

Ms. BROKENROPE. I have it.

Mr. GEJDENSON. Next.

[EDITOR'S NOTE.—The above-mentioned supplemental may be found in appendix I. See table of contents for page number.]

Ms. POITRA. Good morning. My name is Barbara Poitra, and I am representing the Turtle Mountain Chippewa Tribe, for Richard LaFromboise, who was unable to be here this morning. He sends you greetings, and told me to tell you that he does support this bill, wholeheartedly.

One of the reasons being that we have a prevention program in the State of North Dakota, which is funded by the State of North Dakota. I am one of the coordinators for the Turtle Mountain Native American Youth Alcohol Education Program.

This morning, I would like to share with you, some of the things that we are doing in the prevention program, that has been established for 4 years.

I would like to mention that we have been refunded by the State of North Dakota, one of the very few programs that was given a little more money for the next 2 years.

I read the draft of the bill and I am really excited that even if it is a beginning, I remember 6 years ago when we were beginning on our reservation in our State, for four reservations asking for help from the State for a prevention program for our youth.

I put some statistics in a packet of information. Also, some information on prevention programs. Also, some letters from school officials, school psychologists, and other people that utilize our program, and are receiving benefits from our program; what they have to say about it. I think that will be helpful.

I would like to address the cost that I figured out, per student, on our reservation. Total as of March, when I went before the State legislators, was 30,000 students. This, of course, being that we counted each student over and over again, because we have gone back many times during the year.

But, the cost per student on our reservation is $20. That was in the last biannium. I'm sure that it will be more this year, but not that much more. The cost for one adult person going to treatment, or one juvenile in any institution, the national average is $3,500 for 4 weeks of treatment.

So, the cost, comparing the cost of educating, and intervention, there is just no comparison. $3500 compared to $20, is a lot. Your insurance policies usually allow you $3,500 to $4,000 worth of treatment every year, once a year. So, you can multiply that by the number of times habitual offenders receive treatment.

I think prevention is the area that we should have looked at many years ago. I have said that over and over again. I am not telling anybody that they are wrong, I was asked that question once, if I thought they were wrong.

But, I think the education, along with the fun activities that prevention programs use, deters the use of alcohol abuse. Not only that, the children are taking the information that they learn, home, to their parents, their brothers and sisters, and all others, significant others.

We have received quite an impact from the parents. I am always quoting a little boy that was on a picnic and he was in one of our summer programs. He told his mother—she was going to have a beer—so, he told his mother, mom, do you know what that is going to do to your life.

Something that he saw in a film struck him, and stayed with him, and he shared that with her. She later shared that with us.

There was an article in the New York Times in October 1975, that I will quote from Dr. Uri Lowenthal. I have used it quite often, and it is quite short.

It says, kind of how we feel about saving lives, especially our youth. "Human life is unique, cannot be recovered and has to be saved at almost any cost."

That is how I feel about saving our youth from the use and the fatalness of chemicals that they use. Somebody asked earlier about the Lysol spray; is that right?

Just recently, I attended a meeting at the State capital where a doctor at the University of North Dakota would like to do some research on the hair spray and the Lysol spray.

In the State of North Dakota, we have had two recent deaths from the same family, I believe, from Lysol spray. The most abused chemicals on our reservation, of course No. 1, alcohol, and No. 2, would be marijuana and other drugs. That is what they say.

But, the kids I work with, it would be sniffing gas paint, Lysol, Pam sprays, and other kinds of sprays, and then, marijuana and other drugs.

I personally would like to commend you and the whole committee, for considering saving the lives of our Indian youth. Thank you very much.

Mr. **Gejdenson**. Thank you. Let me tell you that one, your own Congressman, Congressman Dorgan, is very supportive and has been very helpful. You cannot put everything in dollar and cents terms, but certainly Washington ought to understand this. It is a heck of a lot better to spend $20 or $30, than the problems you will have down the road.

Ms. **Poitra**. Right.

Mr. **Daschle**. Mr. Chairman, I would like to just commend our panel, and I think again, some excellent testimony in addressing your questions and your concerns.

I think we need to emphasize that really the purpose of the hearings that we are holding here today and down in Mexico and Arizona, and in Washington, would be to take the kind of suggestions you have for improving the legislation, and to incorporate them into an even better bill.

I think that your contribution to that extent has really been helpful. I would address your testimony on page 24, I believe it is, table D. It addresses the cost that I think you brought up very graphically.

On page 24, according to the Research Triangle Institute, the 1983 costs of U.S. society for all alcohol problems was $116,674,000,000. That is an extraordinary statement. Even if it were only half that, and even it were $50 billion, whatever figure it is, as the chairman said, it is not just the cost, but the cost very graphically demonstrates the impact that these problems are having psychologically and socially, but also, economically.

Ms. **Poitra**. I would like to tell you where that comes from.

Mr. **Daschle**. OK.

Ms. **Poitra**. For your information, one of the curriculum for alcohol and drug prevention, is called 8:30 Monday morning. Quarterly, they supplement a book called the Bottom Line, and that is direct out of there.

There are many, in this particular issue, it has State by State. It also addresses and has suggestions for prevention.

Of course, liquor taxes—we're paid with a percentage in our State, with the revenue from liquor tax. There are a lot of suggestions in there.

I also would like to offer our services. We have been asked many times to testify because we have an established program, and we have worked through all of the bugs. Not all of them, but some of them. Our biggest bug is having enough money to go around and keep the program.

However, North Dakota, as you said, Congressman Dorgan and our State legislators are all very supportive of this. They proved that by refunding us for another 2 years, which will make 6 years, plus giving us $30,000 more money.

Mr. **Daschle**. I sense you are a pilot project for what——

Ms. **Poitra**. Yes, yes.

Mr. **Daschle** [continuing]. We would like to do nationally.

Ms. **Poitra**. Yes; it is established.

Mr. **Daschle**. To the extent that you have shown how well it works, I think that you have done the legislation and this whole concept a real service.

Ms. **Poitra**. Yes.

Mr. **Daschle**. We certainly want to thank you for your contribution.

Ms. **Poitra**. Thank you.

Mr. **Daschle**. Thank the panel.

Mr. **Gejdenson**. Thank you very much. We will certainly make note of that to our colleagues in Washington.

The next panel will be Mr. Wallace Wells, Mr. Webster Two Hawk, Mr. Russell Hawkins, Ms. Jean Belille, Ms. Arta Carlow.

Would you identify yourselves?

Is Judge Belille here?

OK, why not go ahead.

[Prepared statement of Jean Belille may be found in appendix I.]

STATEMENT OF JEAN BELILLE, CHIEF JUDGE, WINNEBAGO TRIBE FROM NEBRASKA

Ms. **Belille**. OK. Mr. Chairman and other honorable guests. We thank you for this opportunity to present testimony today.

I am Jean Belille and I am the chief judge in the Winnebago Tribal Children's Court in Winnebago. I am representing the Winnebago Tribe of Nebraska.

On April 9, 1982, the Secretary of the Interior officially approved the Winnebago Tribe's petition for reassumption of jurisdiction under the Indian Child Welfare Act. The effective date of the petition was June 21, 1982.

Since that date, the court has heard nearly 300 cases on the reservation, as well as several out of State transfer cases.

We have heard, out of the 300 cases that we have heard, we have heard 125 neglect cases, 46 were legal custody cases, 23 were child in need of supervision cases, and 72, were truancy cases.

The rest of the cases heard include termination of parental rights, contempt, guardianship, and sexual abuse cases.

Since the beginning of the court, we have served 214 children, 167 parents, and 59 extended family members. Of these total statistics, approximately 90 to 98 percent of our case load is due to the use and abuse of alcohol.

We are here to urge the passage of H.R. 1156, the Indian Youth Alcohol And Drug Abuse Prevention Act. Many of the cases mentioned above involved juvenile parents who have problems with the use of alcohol and drugs.

All of the child in need of supervision cases that we have heard involved teenage children who are heavily into the use of alcohol and/or drugs.

The alcohol treatment facilities that we now have on our reservation, are designed for the adult alcoholic. Our youth are not being served adequately. We have all seen the cycle that alcohol can produce, and it is time we tried to end that cycle. Prevention, identification, and treatment are the only tools that we have at our disposal at this time. Let us make them as well planned and coordinated as we possibly can. This bill is a step in that direction.

As far as the language of the bill goes, we have a few—we would like to urge the following changes. In section 301(b)(2), part (H), in addition to tribal court judges, we would like to include tribal court staff. In section 402(C)(2), part (A), the tribal council should be allowed to appoint a designee to approve such shelters, and not do it themselves.

The only other amendment that we would urge, would be an increase in the appropriation, to include the cost of emergency group shelters. We have a really hard time getting Indian foster parents through the Indian Child Welfare Act, and if we did have a group home, then we would at least be able to put the children somewhere if we do get them.

OK. In closing, again, I would like to urge the passage of H.R. 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act.

Our youth are our future, let us make our future better.

Mr. GEJDENSON. Thank you very much.

The percentage is astounding, that it is that high a percentage of alcohol involvement in the problems. You know, these field hearings always astound me, on how much they bring home the problem. You expect to hear good witnesses with information, but it is always impressive how much we really do get. Thank you very much.

Mr. **GEJDENSON.** We will go—the next panel will be Ms. Peggy Cavanaugh, director of alcoholism programs, Devils Lake Sioux Tribe, North Dakota, Mr. Phillip Under Baggage, director, alcoholism program, Mr. Edmund White Bear, council member, Fort Berthold Tribe, North Dakota.

Peggy Cavanaugh, and your name?

Mr. **THOMPSON.** Rick Thompson. I am with Peggy.

Mr. **GEJDENSON.** OK.

Ms. Jackie Rouse, Ms. Jessiline Anderson, child welfare worker, Omaha Tribe, Nebraska. Mr. Allen White Lightning. Mr. Caleb Shields.

Could you just identify yourselves, each one now and then, we will go back to Caleb and start with him. And, each time you speak, identify yourselves for the reporter, so she does not have to furiously jot down who we are.

Caleb. Just identify yourself.

Mr. **SHIELDS.** OK. Caleb Shields, representing the Montana Inter-Tribal Policy Board.

Mr. **TAKING A LIFE.** My name is Jess Taking a Life, and I am representing Allen White Lightning in the Standing Rock Sioux Tribe.

Ms. **ROUSE.** Jackie Rouse, Yankton Sioux Tribe, Wagner.

Ms. **CAVANAUGH.** Peggy Cavanaugh, representing Elmer White, Sr., Devil's Lake Sioux Tribe.

Mr. **GEJDENSON.** You are Peggy Cavanaugh?

Go ahead, Caleb.

[Prepared statements of Caleb Shields, with attachment, Allen White Lightning, Jackie Rouse, and Peggy Cavanaugh may be found in app. I.]

PANEL CONSISTING OF CALEB SHIELDS, REPRESENTING MONTANA INTER-TRIBAL POLICY BOARD, FROM MONTANA; JESS TAKING A LIFE, DIRECTOR, CHEMICAL PREVENTION PROGRAM, STANDING ROCK SIOUX TRIBE, FROM SOUTH DAKOTA; JACKIE ROUSE, REPRESENTING ALCOHOL PROGRAM, YANKTON SIOUX RESERVATION, FROM SOUTH DAKOTA; PEGGY CAVANAUGH, DIRECTOR, CHEMICAL DEPENDENCY PROGRAM, DEVILS LAKE SIOUX TRIBE, FROM NORTH DAKOTA; AND RICK THOMAS, DIRECTOR, NATIVE AMERICAN ALCOHOL TREATMENT PROGRAM, FROM IOWA

Mr. **SHIELDS.** Thank you, Mr. Chairman. I am Caleb Shields, representing the Montana Inter-Tribal Policy Board, and, also, the Fort Peck Assiniboine and Sioux Tribes of Montana.

Mr. Chairman, we are extremely grateful to you as a congressman, taking up the most difficult problem facing our Indian tribes today, and that is alcohol and drug abuse among our young people.

Many Indian young people have developed severe problems with alcohol and drug abuse before they reach age 18, that they have virtually lost their chance to become stable and productive citizens.

My testimony, Mr. Chairman, is condensed down to 3 minutes. I have for the record, submitted copies of the balance of the testimony.

In presenting the board's view on the bill, I would like to express our support for two provisions in H.R. 1156. First, that the Montana Inter-Tribal Policy Board supports section 205(A) of the bill, which would require the Secretary of the Interior to establish summer recreation and counseling programs for Indian youth.

In the past, several Montana tribes have been able to establish small summer programs for the children on the Reservations. These programs are both effective, and relatively inexpensive. We suggest that either the bill or the committee support make clear that operation of summer programs could be contracted to tribes under Public Law 638. The tribes are certainly best acquainted with the particular needs of the young people.

Second, we would like to express support for section 301(b)(2) of the bill, which would make IHS training on drug and alcohol abuse available to a wide range of concerned individuals, including, any interested member of the Indian community.

We would like to suggest two amendments to titles II and III of the bill. The first amendment concerns section 204, which would presently require BIA and contract schools to provide instruction on drug and alcohol abuse to students in kindergarten and grades 1 through 12.

While this would be very beneficial to students at these schools, we would like to remind the committee that many of the schools on Montana reservations, for example, all four schools on our reservation at Fort Peck, are ordinary public schools. Not BIA or contract schools.

The State public schools receive substantial Federal funds due to their high Indian enrollment, including from the Indian Elementary and Secondary School Assistance Act, and from the Johnson-O'Malley Act.

H.R. 1156, should require these schools, as a condition of receipt of Federal funds on behalf of Indian students, to educate these students on the dangers of drug and alcohol abuse.

I have attached, a copy of draft amendments concerning the Education Assistance Act and Johnson-O'Malley. This should not deter local education agencies from applying for funds under these Acts. Because, provision of drug and alcohol instruction, would be relatively inexpensive.

The second amendment concerns title III. The primary purpose of title III, is to provide education concerning the dangers of drug and alcohol abuse to adults, who are in a position to assist Indian young people.

We must recognize that many of our young people have such serious problems with drug and alcohol, that they can only be assisted by counselors who have received much more intensive training than the Indian Health Service will be able to provide under section 301(b).

At Fort Peck, we regard trained counselors as our single greatest need. The counselors could work not only with our young people, but also with their families, such as family intervention.

The counselors could provide treatment to our young people who are being treated for their problems, on an in-patient basis, and could then provide followup counseling once they are released.

They could also provide outpatient counseling to children who do not need detention, and assist the schools with their education efforts.

We strongly urge the committee to amend the bill, to authorize funds for additional trained counselors.

We have several concerns about title IV of the bill, which concerns law enforcement. We agree that many of the juveniles arrested on reservations in Montana, for problems related to drug and alcohol abuse, would be better off in emergency shelters authorized by section 402, than in jail.

However, particularly in light of the fact that many of the young people arrested, are released to their parents' custody within several hours, we believe that funding for counselors should be a higher priority than funding for emergency shelters.

We are also very concerned about section 402(a)(3). This section of the bill would require the Secretary of the Interior, to develop guidelines to determine when an Indian youth arrested for an alcohol- or drug-related offense can permissibly be incarcerated, rather than placed in the community-based shelter.

Any such guidelines should be a matter for individual tribes, not the Secretary. The authority to establish guidelines governing the treatment of our children belongs to us as sovereign governments.

Section 402(a)(3) should either be removed from the bill altogether, or should be amended to authorize tribes to obtain 638 contracts to develop guidelines for their reservations.

Section 402(c)(3), would require the Bureau of Indian Affairs to develop standards for licensing the emergency shelters authorized by the bill.

This section should be amended to make clear that tribes can develop their own standards for emergency shelters under 683 contracts. And, can also use licensing standards that they have already developed.

We also have several comments concerning title V of the bill. We support sections 501 and 503 of the bill, which would require IHS to determine what residential treatment facilities are needed for Indian youth with drug and alcohol problems. And, to identify existing facilities as could be used as treatment centers.

Section 501, should be amended to require IHS, in making a study of needed treatment facilities, to focus on options that would allow Indian young people to remain near their homes for treatment.

The study should determine how many young people could be effectively treated in small halfway house-type facilities, as opposed to larger hospital-type facilities.

Our final comment concerns the funds authorized in section 603(a) of the bill, which authorizes $5 million to carry out titles II, III, and V of the bill. While we recognize that in the current congressional climate it would be difficult to obtain a realistic level of funding for these programs, we urge the committee to seek more funds.

The administration must be reminded that these programs save money in the long run, because children with drug and alcohol problems become adults who are dependent upon welfare, and develop illnesses related to drug and alcohol abuse.

This means a high level of Federal expenditures over a longer period of time. The Policy Board strongly believes that a small investment in effective programs to combat drug and alcohol abuse will more than pay for itself in financial and human terms.

In closing, Mr. Chairman, I am also the chairman of the National Congress of American Indians Alcohol and Drug Abuse Committee for the last 6 years, and we are delighted with House Resolution 1156.

I remember back in 1980, when the National Congress of American Indians declared war on Indian alcoholism. We basically got all of our documentation and studies that were done previously from the American Indian Policy Review Commission report, of 1976, which was submitted to Congress, as Task Force 11.

I am sure you gentlemen have had the opportunity, or your staff has, to review that report in making your recommendations on Indian juvenile drug and alcohol legislation.

We are looking forward to future legislation such as a possible IAIA, Indian Alcoholism Improvement Act, which would be very similar to the Indian Health Care Improvement Act, which would encompass all Indian alcoholism legislation under one umbrella.

I think that should be looked at as future legislation.

Earlier, in some questions that were given to the panel members, and some of the testimony from other panel members, there is talk about studies being done. And, a recent report from the Indian Health Service, the Indian health provider, you know, there are 787 studies done already on Indian alcoholism, 68 on the Sioux people themselves, and 125 on the Navajo Nation, for a total of around 787.

I believe the studies are fine, but we could go on and on with studies until someday in the near future, what has to be done, I believe, is to promote some type of implementation, or coordination of the studies for future legislation. With that, Mr. Chairman, I will conclude my testimony.

Mr. **Gejdenson**. Thank you.

Mr. **Taking A Life**. My name is Jess Taking a Life. I am the program director for a chemical prevention program on Standing Rock. I am here to represent Mr. Allen White Lightning who is the HEW Committee chairman of our tribe.

You are receiving the testimony prepared by Mr. White Lightning. I would just like to read the first two paragraphs and give you an overview, basically, of what the testimony is about.

The Standing Rock Sioux Tribe, appreciates the opportunity to present testimony before this committee concerning H.R. 1156, a bill to combat drug and alcohol abuse among Indian youth.

The tribe commends this committee for its efforts to address one of the most troublesome problems facing Indian tribes today. As we stated in our comments on H.R. 6196, a predecessor bill, we regard this bill as an important step in solving the terrible problem of drug and alcohol abuse among our young people.

It is, however, only the first step. More Federal funds will be needed in order to address the problem in a comprehensive way.

Of course, the Federal Government will save money in the long run, because children with drug and alcohol problems become adults who are dependent on welfare and develop severe illnesses related to drug and alcohol abuse.

To survive, these adults will need expensive Federal programs over a long period of time. Whereas, programs to prevent drug and alcohol abuse cost relatively little. An ounce of prevention is truly worth a pound of cure in this situation.

Basically, what the testimony addresses is our unemployment situation on our reservation, and a need for recreation activities to be sponsored or contracted by the tribe. Also, instruction for grades 1 through 12, in alcohol and drug education.

The bill calls for instruction for BIA schools, and we are asking that it also address instruction for the public schools on the reservation.

We are also looking at training of school staff. This needs to be lengthy training, and additional counselors placed in these school systems.

We are not in favor of emergency shelters. But, should they become reality, we are asking that the tribes develop their own standards for these shelters.

The reason we are concentrating on additional counselors in favor of the emergency shelters, is that the children are feeling the same hurts, emotional, physical, whatever, when their parents or adults drink in their homes or communities.

Now, what we are looking at, at this point, in many cases, is problems on top of problems. The addresses made this morning were talking about alcoholism, but we are finding problems on top of problems, so we are looking at an emphasis in counselors, and also the role model examples, or references to that that were made this morning.

We do work with all agencies to make this an awareness on our reservation, all public and social service agencies, including our tribal council.

We provide workshops, awareness workshops, sensitivity workships, for these various agencies. And, this would be of tremendous assistance to us if we do receive any moneys, to concentrate on the youth. Because, as we know, anybody in the field of alcoholism realizes that anytime anybody drinks, it affects a lot of people. And in this case, it is affecting our children, severely. That is all I have to say right now. Thank you.

Mr. GEJDENSON. Thank you.

Ms. ROUSE. I am Jackie Rouse, and I am here representing the alcohol program on the Yankton Sioux Reservation.

Members of the committee, staff members. We are here representing the Yankton Sioux Tribe, and wish to submit the following comments on H.R. 1156, the Indian Juvenile Alcoholism and Drug Abuse legislation, for the record.

First, we would like to extend our support for the efforts of Representatives Bereuter, Daschle, Udall, Young, and Williams, who introduced this bill.

We do not see any substantial changes that need to be considered in sections 101 through 202, under title I. But, would like to see a statement included to say that counseling modalities are to be culturally sensitive and geared to meet the needs of our people, the Yankton Sioux.

Title II, section 204, rather than a generic approach to teaching K-12 about alcohol and drug abuse, there should be language included in this section that allows for local tribal input in curriculum development.

This would enable specific cultural input from individual tribal perspectives to fit the needs of each tribe.

Section 205(a)(1). We feel that summer recreation and counseling programs for the youth should be family focused. Section 206. We find acceptable as is. Section 301(b)(1). We feel needs to include State social and economic assistance workers who are working in or near our reservations. Sections 401 through 502, we find acceptable as is.

Section 503, title V, we have for many years, experienced our juveniles being "sent" to treatment. And while these juveniles are in the treatment environment, do fairly well. However, upon returning to their respective communities, find nothing has changed and reengage in the problem areas for which they were "treated" within 2 to 3 weeks.

This would clearly suggest that rather than "regionalize" treatment, there must be family focused programs, not only to strengthen dysfunctional individuals, but strengthen dysfunctional families. Thus, strengthening communities on the reservation.

Treatment programs must be developed and implemented locally to be effective. Indian tribes in general terms, are aggregates of families, and it is the strength of families that determines the strength of the tribe.

Removing juveniles from their respective communities seems inconsistent with the intent of Public Law 95-608, the Indian Child Welfare Act. Therefore, this whole sections needs to be restructured, to enable the development of family focused and community focused programs.

We, too, on the Yankton Reservation, have problems with vandalism, curfew violations, truancy, breaking and entering, theft, and other criminal activity which is 95-percent related to alcohol and drug abuse.

We see a need for year around family focused recreation, family focused treatment, and family focused community activities.

We see a need for more drug and alcohol education and more marriage and parenting education in public schools serving our Indian communities.

We see that family focused treatment centers, must be developed and implemented on reservations to save our youth and preserve our culture, and allow us to grow toward self-preservation and self-determination. Thank you.

Mr. **GEJDENSON**. Thank you.

Ms. **CAVANAUGH**. In support of H.R. 1156, my name is Peggy Cavanaugh, director of the Chemical Dependency Program, representing the Devils Lake Sioux Tribe of North Dakota.

I bring greetings from our tribal chairman, Elmer White, Sr. I have worked with IHS alcoholism programs for 5 years. I have seen treatment programs come and go. I have seen changes in modalities and treatment approaches from program to program.

Two months ago, I experienced through a treatment training program with the native American Alcohol Program, a unique approach to treatment of our Native American people. I feel it is the treatment that brings finally to our people, true healing of heart, mind, and soul.

The holistic treatment approach through the Red Road philosophy, I feel is essential for the recovery of our people and our children.

I would like to introduce Mr. Rick Thomas, director of the Native American Alcohol Treatment Program in Sergeant Bluff, IA, on behalf of the Devils Lake Sioux Tribe.

Mr. **THOMAS**. Yes; my name is Rick Thomas, and I am the clinical program director for the Native American Alcohol Treatment Program.

Taking a look at the Indian problem throughout the United States, we are dealing with six generations of chemicals within our Indian communities. When I say disease, I am not talking about alcohol or substance abuse. Because the patients who are now in treatment were adolescents 20 to 40 years ago.

And, then, you take a look at their children that are coming behind them. The psychological factors, the psychosocial factors of human development. We are dealing with a severe crisis with our Indian youth. We are talking about emotional retardation. We are talking about psychological suicide.

And, also, if you take a look at our prisons and our reform schools in the State of South Dakota, we have 30 percent of our Indian youth that are in reform schools in Flankerton, SD.

We have 45 percent of our Indian population in Sioux Falls, SD. And, I am just talking about the State of South Dakota. That the non-Indian society is also now feeling the bite of the problems that we are faced with, these chemicals within our own society.

The culture that is coming behind our proud heritage and the culture that we live by and stand by, is a new culture coming called alcohol and drug abuse. And, that culture is literally destroying every aspect of the Native American, and every community throughout the United States.

Working and dealing with these people, I am talking about today in treatment, 100 percent of our Indian women are coming from domestic violence, 92 percent of our Indian women have sexual assault, rape, or incest.

And, if these are the mothers and the fathers that are in treatment, you can imagine where our Indian youth is at today. They are literally being emotionally, in human development, as far as being grown up as a human being, they have been deprived of every love, affection, caring, respect.

The school dropout rate: 50 percent of our Indian youth that are in high school today, are going to drop out because of chemicals, 80 percent of our college students that are coming from a chemical environment, are going to drop out because of chemicals. And, so, the severe impact that we have in working with the Native Americans, I feel, that we need a lot of training, a lot of education, as far as inadequacy that is currently being now, to really take a look at the specifics and also the severity of this disease.

I really feel that if my Native Americans really become totally aware that we are able to address the adolescents needs that are so widely needed right now on our reservation today, and also, in the urban area.

And, I feel that with the work, and through this bill, that we can put a stop to this tremendous cycle that is killing our entire race. Thank you.

Mr. **Gejdenson**. Thank you all.

[**Editor's note**.—Additional information pertaining to alcoholism and drug abuse may be found in appendix I, under cover of a letter from John R. Williams, director, Division of Alcohol and Drug Abuse Studies, to Rick Thomas, director, Native American Alcohol Treatment Program, dated April 5, 1985. See table of contents for page number.]

Mr. **Gejdenson**. Ms. Arta Carlow; not here yet, OK. Mr. Basil Brave Heart. Mr. Russell Hawkins. Mr. Webster Two Hawk. Jessiline Anderson. Edmund White Bear. Phillip Under Baggage. Wallace Wells. Dolly Lugar. OK, now identify yourself once, and then before you speak each time, identify yourself.

Mr. **Brave Heart**. My name is Basil Brave Heart, from the Little Wound School, Kyle, SD.

Mr. **Marshall**. My name is Joe Marshall, representing Mr. Webster Two Hawk of the Rosebud Sioux Tribe.

Mr. **Edmunds**. My name is Gayle Edmunds. I am director of the alcohol program of the Rosebud Sioux Tribe.

[Prepared statements of Basil Brave Heart, Webster Two Hawk, and Dolly Lugar, with attachments, may be found in appendix I.]

PANEL CONSISTING OF BASIL BRAVE HEART, EMPLOYEE ASSISTANT DIRECTOR, LITTLE WOUND SCHOOL, SOUTH DAKOTA; JOE MARSHALL, HEALTH PROGRAMS ADMINISTRATOR, ROSEBUD SIOUX TRIBE, REPRESENTING WEBSTER TWO HAWK; ACCOMPANIED BY GAYLE EDMUNDS, DIRECTOR, ALCOHOL TREATMENT PROGRAM; AND DOLLY LUGAR, PUBLIC RELATIONS SPECIALIST, SADD CHAPTER, STATE OF SOUTH DAKOTA

Mr. **Brave Heart**. My name is Basil Brave Heart. I am the employees assistance program director of the Little Wound School, a 638 contract school on the Pine Ridge Indian Reservation.

Mr. Chairman, members of the committee. It gives me pleasure to speak before you and bring some concerns regarding alcohol and drug problems on the Reservation.

I would like to make part of the record, a video tape that was made by the Little Wound School, called "On The Way Back." And, also, copies of the study that was done by the Western Behavioral Science Department, Colorado State University.

First of all, I am very pleased to be part of this hearing. Little Wound School, back in 1983, made a visit to Washington. At that time, we met with Tom and Jan Funk, and we suggested some sort of legislation be initiated. And, I feel that it has come a long way.

And, so, we certainly support this bill H.R. 1156, and we have some recommendations and comments regarding the bill that exists, as is.

First, we would—the Secretary will mandate keeping schools open for summer. Schools to provide alcohol and drug counseling. We would like to include a bill that says contract schools and BIA schools, but also we would like to include other schools, which are parochial schools and public schools, which have Indian populations.

The second thing we would like to recommend is on page 5. We would like the language to be strengthened to incorporate a strong family component. A family program. Require parents and guardians to receive alcohol and drug counseling, whose child has used chemicals abusively.

The third thing is to require, the bill says to offer, but we would like to submit this. That require tribal council members who sit on alcohol and drug boards, to receive extensive training in the area of chemical dependency, and to offer all other tribal council members training. This training will prevent alcohol and drug programs to fail as I have seen in the past.

Too many times, well-meaning people who sit on boards have little or no knowledge of the effects of alcoholism. And, point in case. Sometimes people who are using chemicals, who are hard to be part of a program, can cause such dysfunction and cause such disharmony to a program, that the program becomes ineffective.

Four, the certification requirements for alcohol and drug counselors. I feel that the tribal council needs to develop stringent requirements. A sobriety clause, for example, needs to be placed in there to prevent counselors who have little or no training We are dealing with a disease that is a matter of life and death. And, there is no room for amateurs, or so-called instant experts who come into the field and exploit the field. And we are dealing with a matter of life and death, children, adults. And, I very strongly suggest and recommend that this area be strengthened to protect.

Sometimes, I feel it is better to do nothing than to put in some amateur counselor and to cause much more problems. I also, in this section, in this counselor certification, is to require more BIA 638 and other schools that have Indian students, more counselors. And also, these counselors to receive adequate training.

Number five, the emergency shelter part. I think the approval by the tribal council for licensing requirements needs to be strengthened to improve the quality of services.

Number six. Help tribes plan and construct treatment centers and this will include quality assessment, detoxification, primary treatment, and aftercare.

In addition to this, we think that schools need to incorporate some sort of employees assistance programs.

Little Wound School has demonstrated that an employees assistance program is needed and is very effective costwise.

This bill can be an excellent vehicle, but you need good drivers. You need people that are qualified to implement such programs. So, again, I want to strengthen that.

I think that one of the things that we feel that is very important is that we need not to invent the wheel again, and there are some programs that are working. And I think, that we need to view some of these model programs to share, and expand this bill. And so, with that, is my conclusion.

Mr. GEJDENSON. Thank you. Again, identify yourself.

Mr. MARSHALL. Mr. Chairman, my name is Joe Marshall. Mr. Two Hawk, the chairman of our tribe, has asked me to extend his apologies. There was an emergency in his immediate family and he was not sure whether he could be here.

I am the health programs administrator for the Rosebud Sioux Tribe, and with me, is Mr. Gayle Edmunds, who is the director of the alcohol treatment program.

Our tribe, generally, is in support of the bill, and we hope for its expedient passage in the committee and through the House.

We addressed our testimony to two specific areas; one having to do with the involvement of the family in the treatment process. And, we also address some issues concerning the curriculum to be used in the schools.

Very briefly, Mr. Chairman, and Congressman Daschle, I would like to tell you a story about a young man.

On May 11, 1983, just after turning 18, and 2 weeks before his high school graduation, a young man by the name of Joe Boyd, took his own life under the influence of alcohol. Joe Boyd, was my brother-in-law.

Unfortunately, there are a lot of us in this room who could probably tell you the same kind of story. So, whatever approaches we use are necessary, but we must be careful, that they are sensitized to the issues at hand.

And, one of the areas we are talking about, is the sensitization of the personnel, for example, in school systems, be they BIA or contract or public schools. We would like to support Mr. Brave Heart's comment that schools beyond contract and BIA be included, because there are a lot of, for example, at Rosebud, there are two schools that are public, that have a 55-percent Indian, and one has 85-percent Indian student population. So, I think those kinds of schools should be included.

But, our position is that education is a total experience. It is not just an academic experience. From the time a child goes through—enters kindergarten and graduates high school. From the time he walks into school in the morning until the time he leaves. Whatever happens to him in that setting is part of a total education that he receives.

If a teacher happens to rub him the wrong way or if he does not get along with the teacher for that day, then that has an effect on that child's attitude toward adults, or toward school, or toward authority. So, we feel that school personnel, not just teachers, but administrators, custodians, cooks, all must be sensitized to the total educational experience and, to the social and cultural values of an Indian student.

One other area that we commented strongly on was the curriculum that is to be used in providing information to Indian students about alcohol and drug abuse in that area.

Too many times the curriculum that is used for Indian students is geared to the average middle class American student. And, in order to be effective, we think that the curriculum that is used and developed, should be a little bit more sensitive to the environment that the Indian student lives and functions in. That is the environment that he has to, will spend a large part of his life. Therefore, he must learn all he can about it. Anything that he learns in school, should come from that point of view. So, those are the areas that we choose to comment on.

I will turn it over to Mr. Edmunds.

Mr. **Edmunds.** My name is Gayle Edmunds, and I am the director of the Rosebud Sioux Alcohol Treatment Program.

And, taking off from what Joe has said about the curriculum aspects. I will start off maybe just with a little light joke. And one of the things that oftentimes was taught in early alcohol intervention, was the joke of the worm in the bottle of alcohol and watching what the worm would do.

And, the teacher caught the student drinking later on in the day, and she said, well, I thought that would have some kind of effect on you. He said, well, what I found out is if I drink, I won't get worms. You know, I think that is probably one of the issues that we need to take a look at is that, you know, the bill as it stands itself. As a referral process, I think that is where it is going to stand. And what are we going to do after the referral process that is going to highlight some of the problems that are existing now.

Youth itself will be symptomology for probably a much deeper underlying problem. That is stress and one of the things that Joe has mentioned, and I would like to kind of kick off on also, is the family, the family itself, and some of the problems that underlie that.

And, to add some teeth to that fact, is how are we going to get that family to treatment, if that be the case. The problems that are going to arise from it. We are going to find a lot of abuse problems within the family. Some very serious dysfunctional indications there. Our statistics reflect down to grade 6. And, that is the sixth grade we are talking about alcohol and drug problems. And, let us keep in mind, too, that alcohol and drugs are one and the same. It is chemical addiction.

I know there was some talk this morning about Lysol and there is some mention of inhaling of that. I think we have to ask ourselves one big question, and that is why do people try to escape reality. Because that is the bottom line when you are talking about a sixth grade student zonking himself out. What is going on in his life to make it that way. And I think that is one of the things that is going to happen.

I think there is going to be some reluctance, and I think very justifiably so, from the courts, as well as the school people that are involved in making referrals. There is going to be some real fear in that, where am I going to send these people, where am I going to refer them to. And, I think that is going to be a big issue.

And, I would like to point out in sections 501, 502, and 503, there is a 6-month study for juveniles in need of treatment, and then, a 2-year process for treatment itself, that would provide residential facilities, including detox counseling. I would like to see that accelerated. The 2-year period accelerated to possibly considering 18 months to 1 year. I know that is maybe a little unrealistic, but I think that should be a major emphasis of this bill.

I think it also should include the families in treatment, and we may be talking a minimum of 60 days residential-type treatment that would include the families. Then, we have the catchall of how do we mandate that family to get in, because I think that is going to be very difficult.

In a school setting, in a court setting, oftentimes with the family being involved, there is a reluctance to involve the family, mainly, because of just the factors that are involved there. And I think we really need to address that issue. That is a key issue. Dysfunctional families are indicators. The kids that are abusing today are symptoms. They are oftentimes symptoms of some problems going on there that are much more serious in nature.

There may be some teeth in that, and I think Mr. Brave Heart has already mentioned that. But to encourage, I think it should be to mandate the schools to encourage family participation at some level. There maybe needs to be some more teeth into that.

And, last, I guess in closing. Annual appropriations that are ongoing. This bill could be just a stop gap measure, could be just some kind of an arisement to a lot of things that we have seen happening. Right now, there is an emphasis on this, and there are some real serious problems there. But I would like to see that ongoing. I am talking an ongoing situation that may last for 3 years, on, and annual appropriations to cover that.

Thank you very much for allowing me to address the committee.

Mr. GEJDENSON. Thank you all. Let me assure you, again. I think that Congressman Daschle's pleading efforts here are to take advantage of what clearly is a national recognition that this may be a time that we can move on some legislation.

Basil, again, thank you for your help yesterday. Thank you very much.

Mr. DASCHLE. I would like to just commend this panel in particular. I have been looking at your study as you have been speaking here, the study that shows the survey of spring of 1984, and it really is just incredible. When you look at the figures here of fourth and fifth graders who never used drugs in Pine Ridge. You have got 33 percent of fourth, and fifth, and sixth graders who have used alcohol, 19 percent who have used some inhalants, 31 percent who have used marijuana. And, this is the fourth, fifth, and sixth graders.

That to me is shocking when you say that one out of every three people has used alcohol and marijuana. And they are only fourth, fifth, and sixth graders. And it goes up from there. Seventh through 12th grade, 82 percent have used alcohol, 71 percent have used marijuana, 30 percent have used some kind of inhalant, 24 percent have used some kind of stimulant. I mean, that is a crisis I do not think can be repeated in any other segment of our population.

Have you found a willingness on the part of most of these children to discuss it, to admit it?

Or, do you think that these statistics may be underrepresented by that very fact. That they are not willing to talk, or not willing to, you know, discuss the fact that they have openly used it.

Mr. BRAVE HEART. The statistics of 1980, the alcohol use went from 80 to 82 percent in 1984. We see that as, when you irrigate something, it begins to grow. The program that we have at Little Wound, I think, encourages people to come forth because they have someone that they know can be straight with them, has some skill, and some knowledge in the alcohol and drug, chemical dependency, and families, too.

And so, I think that this report is very conservative. I think that the students that should have been surveyed were absent. They did not come. They were using, skipping. And I think there is a very conservative report.

Mr. **Daschle**. Well, I think if nothing else, if the members of the Interior Committee could see the statistics that your study shows, the devastating numbers, 81 percent for alcohol, and 30 percent for inhalants, that alone ought to be the moving catalyst. That alone ought to be the force that gets this legislation the kind of attention it deserves. And, I am very grateful to you. This is the kind of comprehensive analysis of the difficulties of the problems we are facing, that I would like to share with all of our colleagues.

Mr. **Brave Heart**. I would like to give credit to Manny Mirand, who helped get this program, helped to get this report underway, 4 years ago. Also, Tom, we have given part of the record, a film that was made by the Little Wound School, and it depicts the problem of what you see there, the people who are affected by what is going on on the reservation.

And that, I think the Interior Department Appropriations Committee has seen that. And, I think Mr. Udall has cochair—he told me yesterday that he was going to present this bill to the Senate, and I think that film there, he saw that. And so, it has had a tremendous impact on them, when they can see that. And, people from the reservation, not outsiders, tell them what is going on. And, Gerald Sherman, with us, from our school, made them very, very happy that he did that.

Mr. **Daschle**. Well, once again, thank you. Very excellent contribution.

Mr. **Edmunds**. Gayle Edmunds again. If I may say one more thing. I think on that Colorado study there, there is a critical factor in prevention in the presence, at least, or the thought of peer pressure being the major influence of drinking, and I think that bill reflects, that study, reflects that it is family pressures, family problems, the dysfunctional family has a lot to do with drinking problems or drug problems arising.

Mr. **Daschle**. So, what you are saying is that peer pressure is not a major factor in the use of alcohol and other kinds of chemicals?

Mr. **Edmunds**. No. I am not necessarily saying that it is not a major factor. I am sure it is a contributing factor. But, I think one of the underlying factors there that may be more strongly emphasized, has never been critically looked at, has been the family, the dysfunctional family as it is. It has always been, well, the peer pressure that, you know, the other students may be involved with, oftentimes leads to that. And I think there are some dysfunctional things going on in the family that underlie those symptoms, especially in the sixth grade setting.

You know, when you take a sixth grader that is abusing chemicals, oftentimes it might be, well, how many other sixth graders are doing that. We don't know that for sure, but what may be going on in that family, too. And I think that it is worthwhile to bring that family in and examine some of the dynamics that are, you know, affecting that child.

Mr. **Marshall**. I think if you examined the extended family among the Indian community, you would see why that influence is there. You would be hard pressed to find a family on an Indian reservation that is not somehow negatively affected by alcohol and drug abuse.

Mr. **Gejdenson**. Has that grown in recent years?

Mr. **Marshall**. Yes, it has.

Mr. **Gejdenson**. I think it is increasing, rather than something that has been there, and we have focused on once.

Thank you very much. Frank, do you want to see if we can turn that around. Let me get Dolly Lugar and Margaret Gates.

How many there are you?

Why not come on up?

Thank you very much. Why not just go ahead, however you can work it. Identify yourselves, first, and then you can go through and make your statements. But first, starting over here on your right, the young lady in the purple, why not identify yourself and go across there.

Ms. **Gates**. My name is Margaret Gates.

Ms. **Lugar**. Dolly Lugar.

Mr. **Thomas**. Phil Thomas.

Mr. **Gejdenson**. OK. Now, it is up to you now.

Ms. **Lugar**. I am the public relations specialist for the SADD Chapter. I will do the talking.

Mr. Chairman, members of the hearing board. Last spring a grant was submitted to the region 5 of the U.S. Department of Education in Chicago, IL, to get funding for an alcohol and drug abuse education program.

The proposal required some statistics to document the need for the program. The Standing Rock Community High School was surveyed, and of the 162 surveyed, 59.8 percent answered they do drink alcoholic beverages regularly.

The training took place in November 1984, and an action plan was developed. One of the team members who drafted the program was our driver education instructor, who thought a SADD chapter could become a reality, if students were interested.

We have enclosed a copy of the history of SADD from the SADD chapter handbook, to familiarize yourself with our organization.

[Editor's note.—The above-mentioned information of the history of SADD may be found in appendix I following Ms. Lugar's prepared statement. See table of contents for page number.]

Ms. **Lugar**. Our SADD chapter put information in the newspapers trying to encourage other chapters in our area. We viewed films on alcohol education and planned a SADD day with a film assembly for the entire school. We also had a booth at the school carnival to expose the community to our chapter of SADD.

During the last week of school, we posted throughout the school the enclosed copy of USAA Anti-Drunk Driving Week.

[Editor's note.—The above-mentioned poster may be found in appendix I. See table of contents for page number.]

Ms. **Lugar**. In October, Margaret Gates was a student in driver education. Two students from our school left the first period to go joyriding. An accident happened and her brother was one of the victims. The driver education instructor took the class to look at the vehicle. He stated, "I can't say alcohol was involved here," But, Mrs. Gates, mother of the victim was there and stated, "I can."

Enclosed, is a copy of the juvenile alcoholism court statistics, which shows the alcohol or alcohol related incidences are on the upswing in the Standing Rock Tribal Court.

[EDITOR'S NOTE.—A copy of the court statistics may be found in appendix I. See table of contents for page number.]

Ms. LUGAR. We would like to testify to the need for counseling and summer recreation in H.R. 1156. We need some activities to develop us socially, as well as academically. Presently, there are two 6-week programs, North Dakota Upward Bound, Fargo, ND, and, South Dakota Upward Bound, Spearfish, SD, which involves 30 students from our school.

We need your help to create programs to give us alternatives to alcohol and drugs. We would like to use the remaining time allowed us, to testify to answer any questions you might have in regard to the problem, our wishes, and needs. Thank you for providing us with this opportunity to see firsthand how the democratic process works.

Mr. GEJDENSON. Let me first say that I think the contract you have got here in the back for kids and their parents and the national attention it has gotten, is something that is really terrific. And, if you do not think adults are smart enough to learn from children, we started strapping our two children in in their car seats, as soon as we had them, and then we would jump around and sit at the steering wheel and drive off without our seat belts on.

It did not take long for the 2-year-old to figure out that that was not a very bright thing to do. And so, as soon as we buckled her in she would say, buckle yourself in, and now, we all buckle up as we drive.

And, I think that, you know, the role that teenagers can play, one setting a good example for other young people, and also, making parents come to grips with their own problems, is something that is a tremendous contribution to society.

And, I think, if you take a look at this area, and others, that you have made a great contribution, and I certainly want to congratulate you for the work that you are doing here. Thank you.

Let me call some of the people that were absent earlier and see if we have got them here. If not, we will go down the list further.

Wallace Wells. I am going to get these names right, I have done them so often. Mr. Phillip Under Baggage, Edmund White Bear, Jessiline Anderson, Russell Hawkins. And, Ms. Carlyle, is your friend here yet, your associate; not yet?

Are they here?

Oh, she is here. Terrific. Why do not you two come up and Dr. Steele, and Mr. Wallace Coffey. OK.

Again, let me just—oh, sure. That is no problem. We can hold you up. Maybe we can ask John Williams, alcohol and drug abuse studies, is he here?

Do you want to come forward and join this panel, then?

Again, first identify yourselves from your right over to the left, And then, when you speak, try to point the microphone that is on the middle cord in your general direction. And, the two mikes there in the center there, point them at you, as well as you start speaking.

Please, identify youselves, who you represent.

Mr. **Coffey**. My name is Wallace Coffey. I am the director of the Nebraska Indian Commission.

Ms. **Carlow**. I am Arta Carlow. I am from Pine Ridge. And I am the chairperson of the health board.

Ms. **Tyon**. My name is Katherine Tyon. I am data coordinator for Project Phoenix.

Mr. **Williams**. My name is Dr. Williams, from the University of South Dakota, and I direct the alcohol and drug abuse studies program.

Mr. **Gejdenson**. OK, do you want to start in the center there. I have had you up the most number of times, Arta. Just point that right at—there we go—and see how that works.

[Prepared statements of Arta Carlow, with attachment, Katherine Tyon, Wallace Coffey, and John Williams, with attachment, may be found in appendix I.]

PANEL CONSISTING OF ARTA CARLOW, CHAIRPERSON, OST HEALTH AUTHORITY FROM SOUTH DAKOTA; KATHERINE TYON, DATA COORDINATOR PROJECT PHOENIX, FROM SOUTH DAKOTA; WALLACE COFFEY, DIRECTOR, NEBRASKA INDIAN COMMISSION, FROM NEBRASKA; AND JOHN WILLIAMS, ALCOHOL AND DRUG ABUSE STUDIES, UNIVERSITY OF SOUTH DAKOTA

Mr. **Carlow**. Mr. Chairman, my name is Arta Carlow. I am from Pine Ridge. I am the chairperson of our health board, and we have our written testimony, but I would like to elaborate on some of the other things mentioned in there.

And, first of all, I would like to mention that the Aberdeen area, we do not feel that we are getting enough money because we, like Pine Ridge, we are the second largest reservation, and we are always getting short, and we feel like the Aberdeen area should be getting more money, so that all the service units will be getting more money so that we can have better health care for our people.

When we do not get enough money, why then, our alcohol programs, all our health programs are slowed up. And, so, we feel that that is one of our main things. That if we get more money for our area, that it would help us with all our problems.

We have our ambulance program, and we are just barely existing with that. We did have a detox center, and we had to close that, because of lack of funds. So, that is our main problem, is our funding for all our programs.

And, so, I guess that is all I have to say for now. And, I want to thank you for listening.

Mr. **Gejdenson**. Thank you.

Ms. **Tyon**. My name is Katherine Tyon. I am from Project Phoenix.

Our program is adolescent—for children with alcohol and drug abuse problems. Project Phoenix was established and chartered in 1979, by the Oglala Sioux Tribe, to provide Native American youth with access to in resident alcohol and drug abuse treatment.

Project Phoenix received initial startup funding from the National Institute on Alcohol/Drug Abuse and Alcoholism in 1979.

The Oglala Sioux Tribe contract received continued support from Indian Health Service in October 1982. The board of trustees for the Project Phoenix, consists of members of health board of the Oglala Sioux Tribe who are elected district representatives from nine districts existing on a Pine Ridge Reservation.

Mr. **Gejdenson**. You are doing fine.

Ms. **Tyon**. Project Phoenix is located in the Village of Kyle, which is in the medicine route district on Pine Ridge Reservation.

It is the only existing Alcohol and Drug Residential Treatment Program for Native American youths in the Midwest region, and serves youths ages 12 through 17, who are referred through court order, self-referrals, or referrals by parents.

Youth receiving residential care maintain educational pursuits at Little Wound School. The staff is composed of Native Americans. Clients are referred from seven reservations in South Dakota, and other urban areas throughout the State.

Clients are referred from the States of North Dakota, Iowa, Nebraska, Wyoming, and Montana. Recognizing the devastating effect that alcohol and drugs are having on our youth, the Oglala Sioux Tribe is committed to Project Phoenix to provide treatment for adolescents who are chemically dependent. We average 15 clients daily, and have treated 518 clients since the beginning of our program. We have a waiting list which stays at 30 daily, and there are an average of four youth denied service daily.

We rely heavily on our local resources for support and assistance and treatment programs. To meet our goal, we are improving and updating counseling techniques. At the present, we are arranging classes required for certification in chemical dependency. But, we may not have the funds to accomplish this.

Since your prior visit to Project Phoenix, some renovations have been completed, but our facility, equipment, and transportation are still severely inadequate. We are now in the process of completing a proposal for a new facility, which will double the amount of clients we serve.

In the event we do get the new facility, there will continue to be a shortage of facilities on the Pine Ridge Reservation for all the chemical abused children. Data shows at least 71 percent of the student population of Pine Ridge Reservation used marijuana, 80 percent used alcohol, 30 percent used inhalants, 25 percent used stimulants.

Many of the students are polydrug users. The use of marijuana, inhalants, and stimulants are three times the national average. These statistics were taken from the western behavioral studies department of psychology, Colorado State University.

The goal of Project Phoenix is to develop high motivated youth, exhibit productive and responsible lifestyle behavior. The goal, as stated, is directed toward four program component areas. Prevention, intervention, treatment, and follow-up.

The prevention program is primarily community based. They are trying to help youth and their families make responsible decisions about substance abuse. The intervention program helps youths who are abusing substances. Those are potential abusers or who come from families with family members who are addicted.

The core of the intervention program is Alateen meetings groups sponsored by Project Phoenix. The group is modeled after Alcohol Anonymous, and provides group support for teenagers. The treatment program is residential. The clients attend Little Wound School, an educational facility that also has an extensive alcohol and drug prevention program.

Project Phoenix treatment program is based on a blending of Indian culture, Alcoholics Anonymous philosophy and methods, and current addiction treatment methods.

As we prepared our testimony we became aware that there is no accurate reporting system for documenting program associations with drugs and alcohol. Also, a little research for documentation is valuable as how do drugs and alcohol affect Native American youth, emotionally, psychologically, and socially.

In our daily lives, we are aware of the individual who was addicted to inhalants or other drugs and has gone through treatment, who no longer uses inhalants, alcohol or other drugs, but is dysfunctional because of what appears to be brain damage.

Most of our contacts with mental health facilities are court systems. There appears to be little help for parents and their families. Most of our clients experience secondary problems in the areas of abuse and neglect associated with alcohoi and drugs. We deal with these appropriately as possible within the time the clients are with us. Upon existing a program, we make recommendations as to appropriate treatment for the client.

We are in dire need of services such as long-term abuse programs, and group homes. Also, community parenting classes directed at all age groups.

The staff at Project Phoenix finds it extremely difficult to work with the youth that are using alcohol and drugs, as a way of coping with the underlying emotional, physical or sex abuse.

The families on Pine Ridge Reservation, are concerned about drugs and alcohol problems affecting the youth. They are frustrated and are seeking help. Help, to gain back the responsibility of providing the guidance and counseling to their children. Helping them, teaching their values to their children. Help in not only teaching them, but also to live them.

In this proposed bill, I see very little emphasis on the need of family. We believe family counseling skills and parenting classes should be amended to the bill.

In addition to the teachers and counselors in the school receiving training in alcohol and drug abuse, we believe all personnel coming into contact with the children, should receive training such as cooks and bus drivers.

We think the amount of money of $5 million appropriated to Indian health in the United States, is severely inadequate. This amount alone is insignificant for the Pine Ridge Reservation.

The Pine Ridge Reservation, being the second largest in the United States, could utilize this money being appropriated and still have need for more. I see a need to triple the size of Project Phoenix, or create two more programs such as Project Phoenix. There is a need for a halfway house and a treatment center on the reservation, as the cost of sending personnel off the reservation is staggering. And, we are in support of the bill, H.R. 1156.

Mr. **Gejdenson**. Thank you very much.

Ms. **Carlow**. May I say something?

Mr. **Gejdenson**. Sure. Go right ahead.

Ms. **Carlow**. Thank you. I forgot to mention we would like to know what is happening to our PID for our hospital at Pine Ridge.

Mr. **Gejdenson**. Are you No. 1 for PID?

Mr. **Coffey**. OK. No problem.

Mr. Chairman, members of the committee, my name is Wallace Coffey. I am the executive director of the Nebraska Indian Commission.

I am pleased to have this opportunity to appear before you to testify in support of H.R. 1156. Further, let me commend each of you for the work you have done in raising these very serious concern about alcohol and drug abuse among our Indian youth.

The State of Nebraska and the Division of Alcohol and Drug Abuse, has financially supported Indian alcohol treatment programs throughout the State.

Currently. $498,000 fund eight programs with priority areas being the three Nebraska Indian reservations, two urban areas of Omaha and Lincoln, and several western Nebraska communities.

It is important to note that these programs center around treatment rather than prevention, and are principally directed toward the adult instead of the juvenile.

When discussing problems and needs in Indian country, and, among Indian people, we mention unemployment, health care, and law enforcement as the greatest problems or among the greatest needs.

We believe that each of these problems are a cause of, a result of, or exacerbated by drug and alcohol abuse. Therefore, we feel a reduction in incidents of drug and alcohol abuse, will make significant improvement in these, and no doubt, other areas.

According to the Caron Institute on Alcoholism and Substance Abuse of Westerly, PA, alcoholism is the Nation's No. 1 health problem. Statistics provided by the Indian Child Welfare Network Newsletter, indicate alcoholism, directly or indirectly, affects 95 percent of all Indian families.

Rarely, is there an Indian family that is not touched by the affects of alcoholism and drug abuse. Many victims today began as very young people. We cannot expect the problem to be solved in a short period. To be effective at all, a commitment must be made for a financially sustained and well-planned attack. We believe that H.R. 1156, could be a giant step in the right direction.

In recent years, education was a priority among Indian leaders, parents, and government officials. They felt that Indian people through education could improve their lives, and fill some of the job needs in tribal government programs, making self-determination a reality.

Because of their concerns, education became a budget and interest priority, and the educational level rose, whereby today, most tribal government program positions are held by Indian people.

We believe a similar commitment concerning the prevention and treatment of drug and alcohol abuse can meet with similar success. H.R. 1156, speaks to this involvement and commitment in section 301, where training in the problems, is to be given or offered to those in leadership positions, or to people who can make a difference. The more people understand how the problem affects their area of responsibility, and how they can cooperate in the efforts, the more effective it will be.

H.R. 1156 is a Drug and Alcohol Prevention Act. We must all realize that alcohol prevention, with existing literature and curriculum is new. Training is similar, but different.

For this reason, we believe most of the effort and sufficient financial resources, should be channeled into prevention programs with specificity in such areas as the K–12 school curriculum, recreation programs, and counseling as mandated in section 204.

I have been informed of a number of organizations and/or institutions, which currently have a culturally related curriculum, which is designed to meet the individual's and traditional needs.

I applaud them in these efforts and recommend that funds be made available for innovative demonstration projects such as these, that can be made adaptable to all of Indian country, and, at the same time, remain low in cost, but highly effective.

Initially, these programs may cost as much to administer at the area level, as is spent on the project. But, for small tribes and organizations, inexpensive programs may be as effective, or more so, than those that take thousands of dollars. And, when funding eventually runs out, it would be much easier to sustain their own budgets.

Presently, the cost of human suffering in incalculable. Every dollar that is successfully spent on preventing an Indian young person from entering the revolving doors of drug and alcohol treatment centers, will be returned manyfold in saved health care expenses, law enforcement and incarceration costs; and, in economic productivity through employment.

We can envision healthier, happier people, more stable homes, and less poverty. To accomplish this, the efforts must be adequately funded. In a time of budget cuts and scarce resources,there is a temptation to tap already strained resources.

A few dollars may be freed through better management and cooperation, but we believe the current available resources are already stretched as far as possible.

If this bill is to offer solutions rather than false hope, it must be funded with some new dollars. We can think of no better investment than in the future of our children.

Off the record, gentlemen, I would like to also say thank you, especially to Congressman Daschle, and Congressman Bereuter, who represents our district. The State of Nebraska, they have a low priority on prevention, high priority on treatment. So, I commend Congressman Bereuter and Congressman Daschle, for looking at prevention in Indian country, and having that insight. Thank you for listening to my comments.

Mr. GEJDENSON. Let me just say that Congressman Bereuter and Congressman Daschle, both are doing a great deal in committees, to keep us aware of these problems. Let me just ask you one quick question. What are the only other States that provide state funding for alcohol treatment?

Mr. COFFEY. There are approximately seven States that have funding similar to ours, but our State allows the Indian programs themselves to administer their own treatment philosophy, as well as their curriculum, and we are very proud of that.

Mr. WILLIAMS. My name is John R. Williams, Ed.D., from the University of South Dakota, and I have been known to speak rather softly, so if you cannot hear me, let me know; will you?

All right. I bring 18 years of background in the field of alcohol and drug abuse to this committee hearing. And, as I start out, I want to thank the committee for inviting me, and I certainly want you to understand that it is quite a privilege for us at the university.

Four years of my experience in the field of alcoholism was rather informal. I was working with the Office of Economic Opportunity, specifically, with Indian tribes in the upper Midwest, and we developed the first alcohol programs for Indian tribes in this geographic region.

The last 14 years have been formal programs at the university. So, I would like to comment on some of the concerns we have had over the 14 years, so we can incorporate them into the existing bill, H.R. 1156.

We started out in the original treatment process with Indian people. We trained male Indian adults in alcohol counseling. We followed that by female Indian alcohol counselors. We followed that, by dealing, to some degree, with families in the Indian world, and now, we are moving to prevention.

And, I do not have any great problem with this constant move, except it points out one grave error that we look at from, I think, the whole national perspective, and that is, we treat alcohol and drug abuse far too casually. We tend to look at this as a fad that is going to go away, and we can apply some kinds of quick fixes and then it is going to disappear in a few years.

We sort of did the same thing with the old Office of Economic Opportunity [OEO], and we still have a great deal of poverty on the Indian reservations, in spite of the some odd 16 or 18 years that we have dealt with it.

We move from treatment to prevention, without even considering the impact of what is happening in prevention. We have lost over 48 beds, treatment beds, in the Aberdeen area.

Who is going to replace those beds?

Where are the people who need those beds going to go for treatment?

So, I guess, what I am trying to suggest to you is that we don't lose sight of the fact that this is an excellent bill, as proposing to an excellent job. But, it is part of an overall problem, and we do not want to drop the other part of the problem and just focus on this particular thing, if I can say that.

We have to elevate the problem of alcohol and drug abuse, equal to any other House problem. Indian Health Service has to be able to gear up, and effectively deal with this kind of problem. The Bureau of Indian Affairs, they are very perplexed about this. They do not have the kind of resources yet available to them to be able to do this in an effective manner.

That is again a reflection of the casualness that we treat this. The Bureau of Indian Affairs has an entire section dealing with education. Indian Health Service has a number of sections dealing with specific health problems. Neither has a section dealing with alcohol, drugs, or prevention. But we see that nationwide. It is not limited just to Indian people.

So, what I guess I am trying to propose to the members of this committee, is that we begin to look at this as a long-term process, and we can no longer go in and train alcohol counselors, or school counselors, with alcoholism. We need to train the entire school staff. We need to train community residents, mamas, papas, this kind of thing. People are very perplexed. They do not understand how to deal with this.

I happen to be a parent, I have two children. I am fortunate, because I am in this business. But, I can tell you that I meet with literally hundreds of parents a year who sit down and say, what do I do with my children. I am scared to death. Magnify that 10,000 times and you are on a reservation. So, this is not something that we can take very lightly.

At the university, we addressed this 10 years ago, by developing an alcohol and drug training program that we hoped would elevate this whole concept to a recognized profession, equal to nursing, equal to education, and so forth. That would then give the various agencies that have to deal with this kind of a problem, a legitimacy to deal with it effectively.

I see in H.R. 1156, much of this kind of activity. You are proposing many, many kinds of activities in there that are attempting to do this.

I commend all of you for this, because, I think it is extremely beneficial. To give you one last example of what I am talking about, I was at Dolnut Community College in Montana, in January, and we gave a 1-day presentation on alcohol and drugs. The entire faculty was not present because they were in their classes teaching.

Now, what is the priority in that school. I guess I would just ask the question today. How many people in education are here in this room.

I think most of the people I know in this room, are either members of this committee, staff people of this committee, or alcohol and drug interested citizens. And that tells it right there.

I think you very much, and I have given you a written statement that you can read. I stayed away from that.

Mr. GEJDENSON. Thank you.

One of the messages that comes back clearly from you and other speakers here today, is we need more than just a person or several key people in the community on this particular issue that we have. The need to cover the community and people that come into contact with kids and others across the board.

Mr. WILLIAMS. If I may just read my very last paragraph, I think I cover that. And, I do not like to read, but I think I can probably do it faster and easier this way.

In my final comments I say, that I hope that when we can focus on Indian juvenile alcohol and drug abuse, we recognize the entire reservation community must become a huge support system if success is to be achieved. Every man, woman, and child must ultimately understand their role and responsibility in the continued resolution of this problem.

You cannot be limited to a select few. I am suggesting that the training and service efforts proposed in H.R. 1156, not be limited to solely BIA, IHS, school and alcohol and drug abuse officials.

If we want to taste success, then mothers, fathers, brothers, sisters, aunts, uncles, grandparents, in-laws, friends, and anyone else residing in Indian communities, must be involved. If we follow this concept, then our chances of success are much greater. Thank you.

Mr. GEJDENSON. Thank you very much.

Can we now have Lois Steele, and Jerry Flute?

Do you want to identify yourselves starting with that young lady at the end.

Ms. FLUTE. Deborah Flute.

Dr. SMITH. Dr. Elizabeth Grove Smith, University of Nebraska, Lincoln, and Association on American Indian Affairs.

Mr. FLUTE. Jerry Flute, Association on American Indian Affairs.

Mr. TROPE. Jack Trope, staff attorney for the Association on American Indian Affairs.

PANEL CONSISTING OF JERRY FLUTE, PROJECT COORDINATOR, ABERDEEN AREA COMMITTEE ON YOUTH AND JUVENILES, ASSOCIATION ON AMERICAN INDIAN AFFAIRS, FROM SOUTH DAKOTA; AND JACK TROPE, STAFF ATTORNEY, ASSOCIATION ON AMERICAN INDIAN AFFAIRS, FROM SOUTH DAKOTA

Mr. FLUTE. Mr. Chairman, members of the committee, we welcome you to Sioux country. The circumstances for your visit, obviously, are not the best, but we appreciate the fact that the committee has taken the initiative to look at a problem throughout Indian country. And, I say that in all genuine sense. That this is a problem throughout Indian country in the United States. It is not exclusive to any particular tribes in the lower 48 or in Alaska.

We are here today, Mr. Chairman, to talk about juvenile alcohol drug abuse and other problems related to that. We have submitted a copy of our testimony, and we will attempt to summarize some of the recommendations that we have on H.R. 1156, as well as to tell you about some of the things we have found in a field study which we have been working on in Nebraska, South Dakota, and North Dakota, involving all 15 tribes in the Aberdeen area.

Mr. Trope, who is our staff attorney, will summarize some of our recommendations. And, basically, I would like to tell you that in working with the 15 tribes, we found that in talking to court judges, juvenile probation officers, youth workers who might be working in child protection programs, group home staff, law enforcement people.

We found that in the 15 tribes, that between 85 to 90 percent of all juvenile offenses are alcohol and drug related. On a few of the tribes, the juvenile judges told us that their case load was 100-percent alcohol and drug related offenses.

We also found that on every single reservation, we have virtually no youth activity. There are very few recreational outlets. Generally, if there are any recreational things, they are school related. During the summer months, there are no activities for the kids, or if they have them, they are very isolated and they are not available to all of the kids on the reservations.

During the course of this study we heard many, many of the horror stories from staff that are working with juveniles, working with parents, and some of the offenses that are committed while kids are under the influence.

Probably one of the most tragic things that we heard was involving a teenage mother who replaced a rag saturated with gas for a baby bottle for a 4- or 5-month-old child.

And, earlier, you heard testimony that children in the fourth, fifth and sixth grade. So, it goes beyond this into some of the younger children who are learning chemical abuse on the knee of their parents, so to speak.

We heard of the incident where two young brothers who had been huffing gasoline, got into a fight over a glass of kool-aid, and one of the brothers killed his younger brother. Situations where aunts and uncles are shotgunned to death, stabbed to death, while a juvenile is under the influence of alcohol and drugs.

And the list goes on. And I am sure that this committee will hear more of these things throughout the course of your hearings, that these kind of incidents occur on reservations, because, in my opinion, we have a runaway problem here.

And, we certainly applaud the effort of this committee and the staff for the work that you are doing. This is certainly a piece of legislation that has been long overdue, and I am sure that all of the tribes that have testified before will tell you that this is a very important piece of legislation for us.

In one incident, the tribal judge asked if our organization could help them to draft a law where they could arbitrarily terminate the rights of parents because the judge was now seeing fourth generation alcoholics coming from the same family. And he pointed out that there were any number of families in that situation on the reservation.

But, basically, the findings that we have made over the past 8 or 9 months on these reservations, all lead to a dramatic need for services which are not available at this point.

Whether we find no activities for the youth or recreation programs, just as important, there are no programs for treating adolescents that are chemically addicted.

We do not find aftercare programs even once the kids have gone through a treatment, a residential treatment program. And, almost every reservation is asking for trained people in the area of counseling. Particularly, in the area of sexual abuse, which is also a very high percentage on every reservation. And, in that area, I know this is not within the purview of the committee at this time, that that is equally as serious as alcohol and drug abuse.

We have a lot of problems in the Federal code at this point on prosecuting sex abuse cases. We have problems in State codes that do not address offenses. There was an incident on one of the reservations where a 14-year-old boy was raped. The perpetrator went free because at this point, there is not a law in the Federal courts on involuntary sodomy. Tribal courts do not have the authority to prosecute felonies. They are limited to misdemeanors, $500 fines, and six month jail sentences. And many tribes, do not have their codes to address these kinds of incidents.

In some cases where the Federal law authorizes the U.S. attorney to use a State law, we find the same problem. The State laws do not cover some of these offenses. So, we find that equally alarming in some of the findings that we have had in our study.

But, rather than belabor the committee on some of these things, I would like to ask our staff attorney at this point to point out some of the recommendations that we have, based on our study, and we will submit testimony at a later date, probably when you have your hearings in Washington, from the Association on American Indian Affairs, that will be more indepth. Jack.

Mr. **Trope**. Thank you.

Mr. **Gejdenson**. Do you want to move the other one, too?

Mr. **Trope**. Thank you. As Jerry indicated, these recommendations are preliminary. We will be continuing to analyze the bill, and talk with more Indian tribes before, as an organization, we are ready to give detailed recommendations.

As you may know, the association is nationwide. A nonprofit Indian advocacy organization. And, we will be continuing to look at this on a nationwide basis. And our board of directors, the majority of whom are Native Americans, will certainly have some input in terms of our final positions on this bill.

But, in terms of the preliminary positions which Jerry's study has indicated, I think the major thing that we found is that there is a variety of problems, and a variety of approaches on different reservations.

Some reservations, for instance, believe very strongly in keeping all their kids on reservation for treatment. And other reservations, have indicated that they would like a regional center for drug and alcohol treatment. Some reservations have indicated that their main need is to have trained youth counselors, and that the training provisions which train BIA superintendents, and different IHS personnel and people that are not really what they need.

Other tribes have indicated that they would like to train the whole tribal council and everyone who is in any way involved in this sort of—with kids in any way, even if it is fairly peripheral involvement.

Given that, I think the first thing we want to emphasize is that in the final draft of this bill, there must be, it must be very clear that the tribes must have input on the local level, in terms of designing their own programs.

It may be that training programs will be developed, and the tribes would decide in different ways who might benefit from such training programs. And, that if this bill does not provide for that sort of input to filter up from the tribes, rather than simply just come down in some uniform way from the National Government, then I think it will be less effective and more costly than it otherwise needs to be.

In terms of some of the specifics of the bill that we are going to comment on at this time, I think one that you have heard repeatedly involves a great deal of support for the K-12 education provision in the bill. But, also, an indication that it needs to be extended to public schools that are on or near reservations that serve a lot of Indian students. That seems to be universal concern among the tribes that were surveyed.

Second, I think we have also found that tribes believe that the terms of the emergency shelter provisions of the bill, that on different tribes you may have different standards for such shelters.

And, that rather than BIA standards for such shelters, there should be a provision for the tribes to pass their own standards, of course, with technical assistance from BIA and IHS, should the tribes request this.

I think a third thing that is very clear is that the tribes believe very strongly in the—that some summer recreational programs would be very helpful. But, as Jerry pointed out, our survey shows that it is not only summer recreation programs that are lacking, but year-round recreational facilities. And, I think that the bill might be improved if we can include some provision for year round.

Mr. GEJDENSON. There are no summer recreational programs at the moment?

Mr. TROPE. I would refer that question to Jerry.

Mr. FLUTE. There are summer recreation programs, but on many of the reservations, they are very limited. They might be sponsored by a local YMCA group, They might be sponsored by a church group and restricted just to members of that church. Very few are reservationwide programs. There are many not available, I would say.

Mr. TROPE. OK. The fourth thing that we would note is that Jerry's study found that the problem with inhalants sniffing of gasoline, sniffing of Lysol, that sort of thing, is quite prevalent on the reservations. And, I am not sure what other drug studies done in non-Indian populations have really shown that level of inhalant abuse. I think the bill needs to specifically say something about that, because it may be the treatment approaches for inhalant abuse, sniffing gasoline at a very young age, for instance, may be different from those that would traditionally be used for alcohol and drugs.

I think at this point, we are not prepared to become much more specific than that, but I think you can get an idea of the direction in which we believe the bill should head. The tribes really have differing needs. And, that probably the single most important thing we found is that while this bill certainly is an excellent starting point, in terms of addressing this problem, that the individual needs of tribes needs to be filtered into this bill. And, that there needs to be some expansion of programs available to youth in addition to specifically alcohol and drug-related programs.

Mr. FLUTE. We found in discussions with residential treatment counselors, that it does require specific training to treat adolescents that are addicted to inhalants. You cannot treat them the same as if they are addicted to any other kind of drug or to alcohol.

Apparently, the medical community has pointed out that whatever the chemical and alcohol is very similar to PCP, and it begins to deteriorate the brain cells at a faster rate.

And, on several reservations, it was reported that teenagers are now institutionalized who are brain dead from inhaling gas over a long period of time.

And, I think that with the additional testimony that we had in our findings from counselors, that inhalants, they really have not gotten a good track record on treating them at all. And that is the reason why we would encourage the committee to consider some elaboration in this particular area, on chemical abuse treatment.

My daughter, Mr. Chairman, is here. I asked her if she would join us. She does not have any statement. She is interested in politics. I said, well, you can join me at the table.

Mr. **GEJDENSON**. Well, we are glad to have her here, and I certainly applaud your daughter and the young people that were here earlier. They are the future. We are just here for a little bit, and it is important for her to take back to her friends, that Government exists, it listens, it tries to do something, and that it is critical that the people in the community speak out.

That, is often the case, Washington tries to jam something down your throat. A lot of times, Washington just sits there and waits to hear from you. And if there is one message I believe, with all of you, is do not just end it here with this hearing, make sure that you write to the President, write to the Bureau, write to your Senators and Congressmen from the States that you come from.

And, even if they are already on your side, it is important for them to hear that you support what they are doing. Thank you very much.

Mr. **FLUTE**. Thank you.

Mr. **TROPE**. Thank you.

Mr. **GEJDENSON**. Let us go down through our missing for a bit here and see who we have got.

Wallace Wells, Phillip Under Baggage, Edmund White Bear, Jessiline Anderson, Russell Hawkins. That is the last call. They can certainly submit their testimony if they are not here. If friends of theirs are here, they can get it back to them. If there is somebody here to replace them. OK. If not, let us hear from the folks in the Government.

Dr. Steele, I think you can finally come up here now. We have got you in the right package. Dr. Sloan, and Dr. Jagger, Jaeger. I keep listening to too much rock and roll music.

If you would identify yourselves for our recorder. First, go through and identify yourselves. OK. Starting from your right, Dr. Jaeger.

Dr. **JAEGER**. Jerry Jaeger, area director of the Bureau of Indian Affairs.

Dr. **SLOAN**. Dr. Terry Sloan, director, Aberdeen Indian Health Service.

Dr. **STEELE**. Dr. Lois Steele, director, In-Med Program, University of North Dakota.

Mr. **GEJDENSON**. Let me, before you start, you are the people we send down here, or from here. One of the things that I would like to hear from each of you is what kind of direction you get from Washington, or those who are above you.

What are the signals you are getting on this, and even other problems if you would like to talk about them. Where do you think we in the legislative process could do more, as we try to give direction to the appropriate agencies. How often do you see the top people from Washington, out here I understand that the reservation is one of the largest in the country.

How many of the top brass from Washington, have come out and actually seen the situation on the reservation. If in your testimony you could touch on some of those things, maybe we can help a little when we go back there and get some of the messages back.

Thank you.

Maybe you can take the center one and point it at you, as well. OK?

[Prepared statements of Philip Under Baggage, Jerry Jaeger, and Terrance Sloan may be found in appendix I.]

PANEL CONSISTING OF DR. JERRY JAEGER, AREA DIRECTOR, ABERDEEN AREA OFFICE, BUREAU OF INDIAN AFFAIRS, FROM SOUTH DAKOTA; DR. TERRANCE SLOAN, AREA DIRECTOR, ABERDEEN AREA OFFICE, INDIAN HEALTH SERVICE; AND DR. LOIS STEELE, DIRECTOR, IN-MED PROGRAM, UNIVERSITY OF NORTH DAKOTA

Dr. **Jaeger**. Good morning. My name is Jerry Jaeger. I am the Area Director for the Bureau of Indian Affairs. The Department of the Interior has not taken a position on H.R. 1156.

I am pleased to be here today to talk about the very serious problems of Indian juvenile alcohol and drug abuse.

The Bureau of Indian Affairs recognizes the need to begin working with our youth at an early age. To help them understand the problems and effects of alcohol and drug use our schools are required to include an alcohol and drug prevention program as part of their curriculum. And, our agency superintendents for education are held responsible for assuring that these programs get implemented by having this requirement as part of their performance appraisals.

Because the type and extent of the program developed is a local school decision, the programs vary significantly. Frequently, programs are developed in coordination with the local Indian health service representative and the tribe, and may be as simple as including a unit on the subject as part of the health curriculum, or as extensive as having speakers and special materials in the classroom throughout the year. In addition, the schools may get involved in referrals to the IHS or the tribal court if a student attends school while intoxicated, or under the influence of drugs.

The Bureau of Indian Affairs' law enforcement and social services staff may also become involved in referring to the IHS a juvenile who apparently has an alcohol or drug abuse problem.

Generally, a juvenile is incarcerated until dried out, and then, is released to the parents' custody. Only when a juvenile has had repeated arrests, will the court get involved.

At this time, there are no juvenile detox centers available in the Aberdeen area for referral. However, we do have a foster care program which includes juveniles that have alcohol and drug related problems. It is very difficult to place these teams into appropriate foster homes and, therefore, they are generally placed with a member of their extended family.

There are no special facilities in the Aberdeen area to specifically house juveniles arrested for alcohol or drug related crimes. There are, however, special facilities that are used specifically for juveniles. For example, the Crow Creek Tribe operates a facility at Ft. Thompson, for juveniles who are runaways, or are considered to have social problems.

Also, the Bureau of Indian Affairs is in the process of renovating several jails in the Aberdeen area, to separate adults and juveniles. These projects will be completed in the next year.

Several tribes in this area participated in a recent study done by the Colorado University, entitled "Trends in Drug Use of Indian Adolescents Living on Reservations: 1975–83."

The study concluded that from 1975 through 1981, there were 6 years of increasing drug involvement among Indian youths. Since 1981, there may be at last a trend toward lower rates of exposure to the drugs. The drop in use is occurring both in the percent of young people, who are trying a drug, and in the lack of current use of individual drugs.

Despite the recent reduction, drug use rates for Indian youth are still exceptionally high, and continue to be grounds for serious concern. About 50 percent of Indian youth are now at some risk due to this drug and alcohol use.

I do not have a copy of the study readily available, however, our Washington office does have a copy that can be furnished to the committee.

This concludes my prepared statement, and I will be

Mr. **Gejdenson**. Let me—let us do this. Can we ask you, what is the Bureau's suggestion, what do they thing we ought to do?

Dr. **Jaeger**. I think the answer here or possible solution is that we do need juvenile detention facilities. We do need detoxification centers. We do need places to send these young people, to help them cope with this problem. These are facilities and services that we do not have at the present time.

Mr. **Gejdenson**. I understand how the bureaucracy functions to some degree. One of the things that I suggest is that, and I understand that you cannot take a central position and I do not berate you for that.

But, one of the things that I think can be terribly important is if you send some of those messages up the pipeline as well.

You do not believe that the present program in the schools is adequate; do you?

Dr. **Jaeger**. No.

Mr. **Gejdenson**. But, you think it is declining?

Dr. **Jaeger**. The study shows that it—that I was referring to, shows a slight decline. I guess I would question the validity of that right now, in light of what we have encountered in the last 5 years in the Aberdeen area.

Mr. **Gejdenson**. Is the Department taking any kind of initiatives on the issue?

Dr. **Jaeger**. The only initiatives that the Bureau has taken in the education process is the requirement that part of the curriculum be devoted toward drug and alcohol abuse prevention programs.

Now, as I indicated, that is not doing the total job. I think it needs to be reemphasized and made a stronger part of our curriculum in all Bureau schools, as well as tribally controlled schools.

Mr. GEJDENSON. What about the summer youth programs?

Dr. JAEGER. Unfortunately, it was not many years ago that virtually every Bureau of Indian Affairs school had a full summer program, for employment, for jobs, for recreation, for teaching, and for training.

These have, for the most part, fallen by the wayside for one reason or another in the last few years. So, very little goes on in the summertime in our Bureau schools.

Mr. GEJDENSON. Are we not giving you enough money in Washington?

Dr. JAEGER. The dollar plays a big part in it, yes.

Mr. GEJDENSON. So, there is not enough money coming down in the budget now to provide these services?

Dr. JAEGER. That is correct.

Mr. GEJDENSON. And when your Agency asks for funding in Washington, do you know if they ask for sufficient funding to be able to provide these services?

Dr. JAEGER. I have no idea of knowing what they are asking for.

Mr. GEJDENSON. Frank, did the Appropriations Committee give them what they wanted this year?

Mr. DUCHENEAUX. More than they asked for.

Mr. GEJDENSON. More than they asked for.

Well, I do not want to pick on you, but you are the only person in front of me. And I would suggest that, you know, one of the things we need to have is the Bureau to play a much stronger role in sending that message back to the Members of Congress.

Again, nothing directed at you. I know how this process works. Somebody in Washington, the administration tells the Bureau what their numbers are, and they had better make them fit. And then, the people who understand the needs, are put in such constraints that they cannot meet them.

But, I certainly hope that you help us get that message back. That it is not adequately done now, and that we had better do better.

Mr. DASCHLE. A couple of questions regarding your suggestion about what needs to be done. All of the things that you addressed were in the area of dealing with situations after the fact.

Dr. JAEGER. That is right.

Mr. DASCHLE. But can I take from what you said earlier that you do understand conceptually, the need for some kind of prevention, some kind of a preventive care program?

Dr. JAEGER. Yes. Certainly, it has to start at a very early age. We have some significant facts of the number of juveniles, 10 years and under, who are involved in drug and alcohol related incidents.

And, it is just astounding when you get down to that low level. So, it is a program that has to start in the preschool years.

Mr. DASCHLE. Conceptually, the way the bill is written, without addressing the specifics, conceptually that is something that you personally could support?

Dr. **Jaeger**. Oh, yes. No question about it.

Mr. **Daschle**. OK. What about the provision in the law or in the bill, I should say, that calls for a memorandum of understanding between BIA and IHS.

Do you think there needs to be more cohesiveness, more of a concerted effort on the part of the two agencies to deal with this issue?

Dr. **Jaeger**. Yes. I certainly do. And, I would certainly support that position. I think by pooling resources, we can accomplish much more.

Mr. **Daschle**. Why do you think there is that lack of seeming cooperation at this point?

Is it because on an agency level in Washington, there does not seem to be any interest in it, or are there impediments that are not obvious to us?

What would be the reasons?

Dr. **Jaeger**. Well, I think that it begins at the Washington level, yes. And I think at the local and the field level, we would like to do a lot more of cooperative type ventures than we currently do. But, for one reason or another, it doesn't seem like we really get to that point.

Mr. **Daschle**. Do you think that by writing something in the law such as this, you would better be able to come to some term with regard to that kind of a—effort?

Dr. **Jaeger**. Yes, sir.

Mr. **Daschle**. One last question. It is my understanding that within the billion dollars that the BIA now has for all of your operations, that there is no money directly related to alcohol prevention at this time.

Dr. **Jaeger**. That is correct.

Mr. **Daschle** And there is very little money, and I would be interested if you could share with me your perception of what percent it might be of money that goes to alcohol treatment once the problem has been discovered.

Dr. **Jaeger**. I would say less than 1 percent.

Mr. **Daschle**. Less than 1 percent——

Dr. **Jaeger**. Yes.

Mr. **Daschle**. [continuing]. Of the money, therefore, is directed within the BIA out of $1 billion for any kind of alcoholism care.

Dr. **Jaeger**. That is right.

Mr. **Daschle**. If you had to list the two or three most significant problems Indian people are now experiencing, would you list alcohol as one of them?

Dr. **Jaeger**. Certainly would.

Mr. **Daschle**. So, if we have alcohol as the single largest problem, or one of the two or three most difficult problems faced by the Indians, and less than 1 percent of all budget within the BIA is now attributed toward the alcohol issue, would you not agree that there is some major distortion in priorities?

Dr. **Jaeger**. I would agree.

Mr. **Daschle**. Thank you.

Mr. **Gejdenson**. Doctor, let me thank you for the assistance you gave us yesterday in seeing the hospital and everything, and interested to hear what you have to say.

Dr. **Sloan**. Thank you very much Mr. Chairman. Members of the House Committee on Insular Affairs. My name is Dr. Terrence Sloan, director of the Aberdeen area Indian Health Service.

I am American Indian, a physician, who is specially trained in internal medicine. And, my prior 10 years with the Indian Health Service has been at the service unit level directly providing health services to Indian people.

I have been informed that, by the way, just to begin, that the Department of Health and Human Services, has not taken an official position on this piece of legislation.

I have been asked to provide you with information regarding Indian health services, for Indian juveniles relative to alcohol and drug abuse. In the written testimony, you will find the answers to four questions that were submitted for me to answer.

I will proceed to summarize some of my thoughts and the Indian Health Service thoughts, with regard to this piece of legislation.

We are very concerned about the enormity of the juvenile alcohol and substance abuse problem in the Aberdeen area. If one analyzes morbidity and mortality data, the leading causes of death in the Indian population in this region, are directly related to alcohol and substance abuse.

Although reliable data is not available to the Indian Health Service, we are aware of several reports from school officials indicating a high rate contact with alcohol in the juvenile population.

The age specific alcoholism death rate between 1980 and 1982, for Indian males, was 4.9 per 100,000, and compared unfavorably with the rate of 0.2 per 100,000 for the United States, all races, in 1981.

Mr. **Gejdenson**. 0.2 for the rest of the population?

Dr. **Sloan**. That is correct, 4.9.

Mr. **Gejdenson**. And 4.9?

Dr. **Sloan**. Yes.

Mr. **Gejdenson**. That is a twentyfold——

Dr. **Sloan**. Difference.

Mr. **Gejdenson**. Better than twentyfold difference.

Dr. **Sloan**. That is right. The data for females is just as disturbing, with the rate of 1.6 per 100,000, as compared with the United States, all races rate of 0.1 per 100,000.

The data clearly indicates the catastrophic consequences of alcohol and substance abuse. If one analyzes the Indian Health Services chart series, the largest discrepancy in eight specific mortality rates, is during ages 15 to 24, with the leading causes, definitely, alcohol related.

The loss of these young people represents a severe blow to the future of Indian people and their productivity. From the written testimony, the Indian Health Service has attempted to approach this problem.

However, if one were to analyze our intervention strategies, it has been clearly oriented toward the adult population. The recent establishment of early education strategies, such as Babes Program and Project Charlie, represent a step in the right direction.

Recently, a multidisciplinary conference on alcohol abuse was held in Denver, CO. Recommendations are being finalized for sub-mission to Dr. Everett Rhodes, director, of the Indian Health Service.

I was very impressed with these recommendations. We in the Aberdeen area are already beginning to implement the low cost and common sense ones. These center around properly educating our staff to deal with this disease, in a more prepared and intelligible way.

We are currently analyzing our system of referral and have found a severe lack of uniformity. Except for Project Phoenix, there are no special alternatives for juveniles.

As a clinician, I am fully aware that many times a presenting symptom for juvenile alcohol abusers is death or serious injury. Adolescents rarely appreciate the consequences of serious injury or illness. In fact, psychologically it is difficult to approach adolescents with health issues. Therefore, it is imperative that preventive programs address this issue in a firm manner, and involve the educational system on the reservations.

Early detection should be concentrated outside the hospital and into the community. After detection, there should be a clear age specific referral system with sensitive culturally aware counselors.

Clearly the lack of hard data impairs our ability to approach this problem. It is probably related to the Indian Health Service data reflecting in-stage consequences of the problem with our hospital based system.

A more comprehensive approach utilizing several agencies would be an improvement, epidemiologically. In summary, this is a serious problem. The data base to approach this problem, is inadequate. The approach must be unique. I feel Indian Health Service is beginning to approach this disease in juveniles.

I wish to sincerely thank you, and members of this committee for their interest in Indian health. I would be willing to answer questions. As well, I would also like to have Dr. Lois Steele make a statement.

Mr. GEJDENSON. Thank you.

Before we go to Dr. Steele, and again, I am not picking on you personally for the policies that exist. I think we all end up in the same kind of log jam that those of us in Congress do not always take responsibility for what the Congress does collectively. If it was up to Congressman Daschle and myself, this bill would be law, and not simply being talked about.

How is your Department responding to the general needs. I think one of the things that all of us knew when we got here and it was reinforced by much of what we heard today, is that it is not just the fact that spontaneously a 10 year old starts drinking alcohol or abusing other substances, that there are some problems out there on the reservation. Here, we have got sanitary problems, we have got large numbers of hepatitis cases.

Is Washington releasing the funds?

Are we getting the funds here to hook up sanitary facilities to the homes?

Are we doing the other kinds of home visits that are necessary to make the family aware of general nutritional and health care concerns, that families need to be made aware of?

I know, I live in a rural district in Connecticut. Not quite as rural as your State, Tom, but rural by Eastern standards. And, we are having some problems in the general budget where home nurse visits are being restricted. And, you know, we can remember families that were having problems with hygiene and other areas. And the home health nurse aides and nurses that showed up made a major difference in helping them pull their lives together.

Are you able—what percentage are you able to do what you would like to do?

Dr. **Sloan**. I feel that there is, of course, a tremendous unmet need with regard to health care on Indian reservations. In the field of alcoholism, for example, we currently receive $2,000,000 directed toward alcohol treatment. That represents 3.8 percent of the Aberdeen area budget.

Many of our other specific funding levels are directed toward direct care, community health nursing, et cetera. And, in general, those levels of funding are just adequate to meet the very minimum need of the Indian population.

Mr. **Daschle**. Dr. Sloan, I want to thank you for your comments, very excellent remarks, and very helpful to us.

I would ask a couple of the same questions that I asked of Dr. Jaeger. One, relating to budget.

Is is accurate to say that the budget of IHS is approximately $900 million?

Dr. **Sloan**. Yes. That is correct.

Mr. **Daschle**. Of that $900 million is it also accurate that $24 million is currently spent on alcoholism treatment programs?

Dr. **Sloan**. That is correct.

Mr. **Daschle**. So, $24 million out of $900 million, is currently being devoted to what you describe as the number one health related problem on the reservation?

Dr. **Sloan**. That is correct.

Mr. **Daschle**. What do you think that says?

Dr. **Sloan**. Well, I certainly would hope that there could be some redirection with regard to how funding is allocated.

Mr. **Daschle**. Is it not incredible to both of you that here we are, both, you know, in sort of a universal admission, that we are talking about the single most severe problem our Indian people are facing, and within the BIA there is probably nothing. And within the IHS, there is only $24 million being spent to cope with this.

It just begs the question, why. And, your answer when I asked the first time, was well, I hope we can redirect. But, is there a political problem with it, or is there a lack of recognition of what we all understand to be the difficulty here, or is there a determination that it is someone else's responsibility?

What do you see the reason for that incredible lack of prioritization to this problem?

Dr. **Sloan**. I think, in answering that question, I think that there is some historical perspective in that in the beginning, with Indian Health Service, priorities were with regard to some of the severe epidemiologic infectious diseases that were just ravaging Indian people.

From that time, there has been an evolution because many of these problems are being approached in a more comprehensive manner now. Tuberculosis, for example, although not fully controlled, is certainly more controlled than it was.

In many Indian Health Service areas, except this one, the infant mortality rate has certainly come under control. I think that now, there is a general recognition, that alcoholism is a very serious problem. I think that the department is beginning now to cope with methods and strategies to approach this problem, and is going to need a lot of direction, both from the tribal community, as well as from the legislative process in order to successfully approach alcoholism. I think that talking with the department, there is little doubt that people recognize the severity of the problem.

One of the difficulties is designing an appropriate strategy so we can be successful, simply because we do not have dollars to waste. The amount of money allocated to Indian health service, has never been fully adequate to deal with all the problems, and we have to choose very carefully in our strategies to be successful.

Mr. DASCHLE. If you were to say to those in Washington, we must understand the significance and the ramifications of this problem beyond whatever little contribution this particular bill may make, and you had them to estimate how much in resources it would take, financially, of course, to successfully cope with it on an annual basis, can you give any estimate?

Dr. SLOAN. Clearly, I do not feel I have the expertise to give a gross estimate. And, this is based on at least my review of the literature which shows a lot of intervention strategies are still under evaluation and no one is entirely clear what it is going to take to approach this unique problem.

But, certainly, it is going to take a large amount of funding to train and educate counselors, set up the right referral centers, et cetera, to successfully approach it. Some of the successful data comes from Canadian studies, some from haphazard American studies, that usually are not very well-controlled.

But, I would say, you know, in my opinion, it is going to take a lot more funding than what Indian Health Service currently receives. And, I think, perhaps, that when one looks at the level of funding proposed in this piece of legislation, it is a very initial beginning as far as approaching it in juvenile.

Mr. DASCHLE. But, other than to say it will take more than $24 million, you are not able to hazard a guess?

Dr. SLOAN. Uh, not that—no, I am not.

Mr. DASCHLE. Is it your understanding, let us put it that way, that BIA and IHS will be asking for a significant increase in funds to deal with this issue in the next fiscal year?

Dr. SLOAN. I am not aware that Indian Health Service is requesting more funds.

Mr. DASCHLE. In a sense then, what you are saying, is that while there may be a gradual increase in the amount of understanding and even sensitivity to the problem, that we are still at the lip service level when it comes to any transformation of that understanding to a real concerted attempt to focus on the problem in a realistic way.

Dr. SLOAN. I think if one looks at the approach to the problem, I think that with the increased recognition, I think the Indian Health Service is going to direct efforts to improve the program.

For example, the early education program, Project Charlie, et cetera. These are very innovative ways of approaching the problem. But, without redirected funding, without special legislation, it is going to be difficult to comprehensively approach the problem of alcoholism.

Mr. **Daschle**. One last question. And, that is primarily for the record. Do you see an advantage to pooling resources, and to develop this memorandum of understanding between IHS and BIA, with regard to addressing this issue?

Dr. **Sloan**. Yes. I think that is very good strategy.

Mr. **Daschle**. Well, I have known for a longtime that you both have been very helpful and we sure appreciate your turnout this morning.

Mr. **Gejdenson**. Let me ask you one more question before I let you—what is your total health care budget for the area.

Dr. **Sloan**. $70 million.

Mr. **Gejdenson**. And how many people are you serving with that?

Dr. **Sloan**. Uh, 70—about 75 million.

Mr. **Gejdenson**. And, what do you feel you are able to accomplish with that, 50 percent, 60 percent?

What do you reasonably think ought to be done?

Dr. **Sloan**. Well, of course the Department would feel that there is certainly adequate funding available to the Aberdeen area.

Would you ask me that professionally?

Mr. **Gejdenson**. Yeah.

Dr. **Sloan**. As a professional, I feel that the funding definitely inhibits our ability to provide adequate health services for the Indian people.

Mr. **Gejdenson**. Can you, and I do not want to get you in trouble with the guys in Washington. Do you have a gut feeling of are we doing 50 percent of the jobs, 70 percent of the job, 2 percent of the job, as a professional.

Dr. **Sloan**. As a professional, it is always difficult to categorize percentages. I think that once someone comes into our health system, you know, that that professional tries to provide the very best care. So, I think that with health care, there is nothing satisfactory below 100 percent. But, there is tremendous lack of manpower and there is tremendous unmet need. So, I think it varies from 100 percent, down to zero percent. There are people who do not have access into our system, because we do not have the types of clinics, et cetera.

Particularly, in this area, patients travel miles, 90 miles, 100 miles to receive treatment for strep laryngitis.

Mr. **Daschle**. Could I ask a question another way, Sam?

Mr. **Gejdenson**. Sure.

Mr. **Daschle**. How many people, if 100 percent of those affected by alcohol and chemical dependency is the total pie, what percent under current financing restrictions do you think we are reaching?

Dr. **Sloan**. I just do not have a data base to give you an answer on that.

Mr. **Daschle**. It just in, and I will only press it to this extent.

Dr. **Sloan**. Yes.

Mr. **Daschle**. Would it be fair to—could you say—in round figures, less than a fourth or less than one-half of less than three-fourths, all of them?

Dr. **Sloan**. I would say that we are looking at, and this is based on professional opinion, less than three-fourths.

Mr. **Gejdenson**. Thank you very much. I might just say before we turn to our last witness, that if you drove that 90 miles in Connecticut, you would probably hit 30 hospitals, and those hospitals would include everything from Yale, New Haven, to hospitals in cities like Bridgeport.

And, I understand the density of population issue, but the time in moving patients and services that are readily available, make a tremendous difference in providing service.

Go right ahead.

Dr. **Steele**. My name is Lois Steele. I am an enrolled member of the Piscataway and Sioux Tribe from Fort Peck Reservation. I was raised on that reservation and until I went to medical school, I thought everybody drank unless you were religious or you were a reformed alcoholic. And, I grew up thinking that everybody drank.

Now, I am not allowed to give written testimony here, because the official testimony has been given, but I do run the In-Med Program at the University of North Dakota, and I am here mostly to answer questions for you.

I thank you for allowing me up here before you. I have a very deep interest in this. I taught on my reservation. Taught on several other reservations. Taught school for approximately 10 years before I went to medical school, from sixth grade to 4-year college. I am now assistant professor in the School of Medicine at the University of North Dakota.

We have, the last 2 years, conducted domestic workshops—domestic violence workshops, child sexual abuse workshops. Before that, we did a workshop on alcoholism.

I have been appalled by the number of statistics that have come out for these workshops, since I am a commissioned corps officer in the Indian Health Service, and these statistics came out at workshops, I cannot speak to them as official statistics, but I have been very amazed at the number of students that have taken our workshops, and what the speakers have brought to me.

As I say, I have a deep interest in this legislation from a personal level. The American Indian Physicians Association has set up a meeting after our conference, where we talk about problems that we, as Indian physicians are having.

The first such meeting was held last year and Duluth, and we talked about the amounts of alcohol and depression that we, as physicians that supposedly have had the best of the education, and now, are able to share in all of these economic resources that America has to offer. And, we are still finding that we are losing physicians, Indian physicians through alcoholism.

And we talked about the cry there, some of that was confidential within the group, but the problem exists from the sixth grade, that I have seen, personally, all the way through to my college level with Indian physicians.

When I was teaching on my own reservation, we lost one child for sniffing paint. He fell off a carriage, crushed his head, or had a concussion, died. I was told that there are over 70 cases of child sexual abuse reported in Indian health service at Fort Peck Reservation, but only in 7 was there enough evidence where we could even have any type of intervention by the law officials.

Again, my cousin happens to be a juvenile judge at home, and he was talking about the problems with only being able to prosecute with 6 months in jail, and $500 fine. And a lot of these child sex abuse cases, are the outcome of this alcohol problem.

I was one of the 40 physicians asked by AMA to come down to work on workshops for child sexual abuse and I guess I have been—I was not getting involved. I tried not to get involved with everything, somehow I do, and that has been just appalling.

And, physicians have not been trained in many cases to even diagnose it. And, yet, we are seeing almost an explosion of this type of behavior. And I am very concerned. I still have a lot of relatives living in reservations. My brother is community college president. I know what is going on back there. I am very, very concerned. And I would be happy to answer any questions that I can.

Mr. GEJDENSON. Again, I will give you the same disclaimer. What I say to you is not to pick on you, or what you are doing, but—and I understand the constraints and the system. But, unless we get the information, unless, and you have got to remember that it gets filtered once more, you know, Congressman Daschle and myself relating what we get here, it is never as good as seeing it first hand, being out on the reservation, and getting a sense of what is out there and what is not out there. The condition of the school buildings, the opportunities for activities for young people.

Give me just, not a scientific sense, almost, but the personal sense, is it worse today than when you were a kid. You know, it is hard to say, as a kid you miss a lot, I think.

Dr. STEELE. I think it is worse today from what has been coming back, and I think we had more grandparents that could help before. And now, some of our grandparents are drinking. That, you know, I think it is worse today, but I am not out there on a daily basis.

Mr. GEJDENSON. Are the scholarships we provide in health, are we putting them in the right places?

I mean, is somebody in Washington saying we are going to have 50 scholarships in this program and it is not what you need?

How much—one, are we doing what is right, and how much do we in Washington, listen or get to hear your needs?

Dr. STEELE. Well, I have been told that there are 150 new scholarships available for next year for Indian health service. The priorities are, first of all, people that have been admitted to medical school. Second, nursing. And, for these 150 new scholarships, I know that the Billings area told me that they turned in about 80 applications.

Mr. GEJDENSON. This is scholarships?

Dr. STEELE. IGS scholarships.

Mr. GEJDENSON. For Indian children to go to school.

Dr. STEELE. To go onto health careers.

Mr. GEJDENSON. And this 150, covers what area?

Dr. STEELE. This is nationally. The new ones. Now, we have some continuations.

Mr. **Gejdenson**. All right.

Dr. **Steele**. I know we will be continuing probably 30 to 40 students.

Mr. **Gejdenson**. We are going to provide 150 scholarships.

Dr. **Steele**. New ones.

Mr. **Gejdenson**. New ones. This is for kids graduating high school, in the health area?

Dr. **Steele**. In the health area.

Mr. **Gejdenson**. For mostly parts of the country, Indian and non-Indian where there is the lowest per capita number of doctors and nurses, I would think, as well. And we are providing 150 scholarships for the entire country for Indian children?

Dr. **Steele**. This is what Rockville told me. No, this is for IHS, Indian Health Care Improvement Act scholarships.

Mr. **Gejdenson**. OK.

Dr. **Steele**. Public Law 94-437.

Mr. **Gejdenson**. Specifically, in the health care area——

Dr. **Steele**. Yes.

Mr. **Gejdenson** [continuing]. Than through the IHS budget, as compared to other funding that is available to provide 150.

Do you know how many other scholarships we provide; significantly more.

Dr. **Steele**. You also are providing——

Mr. **Gejdenson**. Do other titles cover health professionals; title IV?

Dr. **Steele**. Yeah. Title IV, Indian Education Act, can cover students that have been admitted into medical school, into graduate programs in other areas.

Mr. **Gejdenson**. Do you know how extensive that is?

Dr. **Steele**. Well, Mike Daas, and Mike Daas, is no longer there, but he told me the last group that he had monitored, there were five.

Now, I used to read on those years ago, but they have not been very extensive.

Mr. **Gejdenson**. What about are we putting it in the right places?

Dr. **Steele**. Well, the top priority, our people are admitted to medical school, and the second priority are nurses. And we have been told that we can submit other students, in other categories, but they will probably not be funded.

We have been trying to submit students in clinical psych. That was about 3 years ago. We do not submit those any longer.

Mr. **Gejdenson**. Just because they do not get accepted?

Dr. **Steele**. They are not getting accepted, and we are having difficulties there, because if we raise them through the ranks to go into clinical psychology training, and we have no money for them, we are raising students to even lose more faith.

We have one student at the In-Med Program right now in clinical psychology. In order to get into this program, she had to compete against 700 other people. There were 700 other applications for this approximately 10 or 11 slots. And so, we were very fortunate in getting her in. She is not being supported by the Indian Health Service at this time, but she is picking up odd grants here and there, teaching for it, whatever we can do to help her.

We have not had anybody else accepted. It is a very difficult program in most universities to get into.

Mr. **Gejdenson**. What can a tribe do to help provide training?

Are there programs that the tribes could do with other resources that they maybe could direct to this kind of training?

Dr. **Steele**. Standing Rock Sioux Tribe has tried very hard to get the priorities changed and especially put a lot of pressure on us to take people in clinical psychology. And, we have received letters from Standing Rock Sioux and requests from other tribes to please look at this. We do not set the priorities.

We have approximately 31 applications right now, just for our junior high and high school program that we run during the summer from Pine Ridge. We can only accept two to three of these students on our funding, unless there are not qualified applicants from the other 22 reservations. Because we accept from 50 to 75 students for the summer program.

Now, Rosebud has given us $1,400 to take a couple more of their students. And that tribe somehow came up with this amount of money.

Mr. **Gejdenson**. How much money is it?

Dr. **Steele**. $1,400. So we can take —costs almost $1,000 per student for the summer program when we consider teachers, we usually squeeze a few more in. We are going to try to take three more from Rosebud for that one.

Mr. **Gejdenson**. The summer program for junior high students?

Dr. **Steele**. We start students at junior high and go through grade 12. It is funded into HCOP and IHS. HCOP, the Health Careers Opportunity Program is from HHS, disadvantaged assistance group. We have to prove these students are disadvantaged. I have asked for a definition of disadvantaged, and been told that the economic disadvantage has to be considered.

This has brought some problems, because the cutoff for economically disadvantaged varies. Many people get angry, but we really do try to take those that are the most economically disadvantaged on this.

Students that are from broken homes, students that are sexually abused, that have been runaways, and yet, they are the brightest. And, we are having problems now.

We have had students coming in that have been sodomized, abused, that are alcoholics, and that takes more counseling time.

And, that, of course fills costs. So, we have to limit the number of students that are really having these kinds of problems, just because we cannot handle them.

Mr. **Gejdenson**. I do not know where it is now, but I just—that is okay. I just earlier saw a pamphlet that listed the hundreds of studies on Indian alcoholism, 717, and I saw a 900-number, and the different disciplines that executed the studies.

Is the research that has been done adequate?

Has it been carried out by the proper disciplines. And you might all want to comment on this.

Do we have the information that we need to move forward, or at some point are we going to be told by somebody that Mr. Daschle's bill is a good bill, but we have got to study things before we go forward.

Now, sometimes you are told to study things because there is really a need for additional information. And, sometimes, people tell you to study things because they just want to stall the process.

Dr. **Steele**. In the early 1970's, I went to Dawson College at Glendive, MT. And, at that time, I was dean of women, and one of a team, one of a two-member team to work on alcohol and drug abuse problems. And, I was the scientific member of the team. This other woman was the social science member. And at that time, we spent a full summer just studying alcohol and drug abuse.

And, of course, I looked at especially the Indian reference materials. I have some more recent studies right here. I know of two studies that are being done at the University of North Dakota at this time. There are a lot of studies. We do not know how good some of these are. I am sure there is somebody that is sitting someplace looking at all of them and putting them together.

Mr. **Gejdenson**. We hope.

Dr. **Steele**. Recently, I have not had time to do so, but you know, there is a whole booklet. Research on issues, drugs and minorities, here is a bunch more. We have got a lot of studies.

Dr. **Sloan**. I think you have one more, to consolidate all the data that certainly, the problem has been adequately studied.

The difficulty is some of the study protocols are not adequate. Second, the—no one has really, to this point, if there are 700 studies available, I think consolidated dH data so that we really know what direction they are pointing to. It could be that the problem has been studied so extensively that no one has been able to compile the data into a useful, manageable tool.

Mr. **Gejdenson**. Dr. Jaeger?

Dr. **Jaeger**. Yes, sir.

Mr. **Gejdenson**. Is there any comment on that?

Mr. Daschle?

Mr. **Daschle**. Mr. Chairman, I guess I would just reiterate my utter frustration at the thought that after 717 studies of all the tribes, only related to alcohol, that all we have out of $2 billion is $24 million in alcohol treatment. That is incredible to me.

I mean if we did not count IHS or BIA then to do as we suggest, which is an excellent suggestion, to consolidate that information and put it in some bibliography, and to utilize for the extension of whatever else we might do, that would make sense. But, it is an absolute shocking tragedy that we are not doing anything more than that, given the resources that we have.

I would like to find an answer to the question the chairman had with regard to tribes. But, what about voluntary organizations, are they visible on the reservations, are they doing anything to help offset the lack of attention obtained through the departments?

Is there any one organization that is a model agency with regard to voluntary treatment of alcoholism, either prevention or treatment after the fact?

Dr. **Steele**. I do not know. I think that the State of North Dakota, has tried. Ms. Poitra, certainly sounds like she has an excellent program. We have heard good things about it. I have some information on the Standing Rock Sioux, and Devils Lake Sioux programs that, again, are funded by the State. All of these are a little different. I really do not know.

I do know, that on my own reservation, the dropout rate when I was teaching, was not as high as it is right now. The high school dropout rate has become terrible. And yet, in that, we are able to turn around a college dropout rate. The national dropout rate for Indian college students is about 50 percent. Dean Shavers sometimes puts us a little bit higher. Whereas, that in that, we are able to have an 88-percent retention rate.

So that summer programs, and pride programs, ideas of economic development, these things can work. I think we have got a lot of studies that have to be made cost effective, but I think that things can get better. If I did not think that things could get better, I would have stayed home this morning. But I think that we really have to work at it and believe in what we are doing.

We are not meeting the needs for the students that want to get into programs, and want to do more. The idea that we have since 1980, started to receive about 350 applications every summer for 50 to 75 positions in the summer program, tells me the students want more. We are not providing.

Mr. **Daschle**. Thank you.

Mr. **Gejdenson**. We have got two additional individuals interesting in testifying, and we have got about 14 minutes left, keeping in a great schedule here.

Is Ms. Cindy Jones here, and Dr. Jud Reaney, and Dr. Williams, did you want to—I saw something that got you going. Why not come up and say it. Is Cindy Jones here?

Ms. **Jones**. Yes.

Mr. **Gejdenson**. Here she is, all right. Why not just go ahead and identify yourself, and you can briefly make a comment. Cindy, you can sit right down here.

Ms. **Jones**. OK.

Mr. **Williams**. Just in reference to the research studies on alcoholism. Recently, the University of South Dakota had the National Institute of Indian Mental Health Research proposed grant, which was formerly called the White Cloud Research Center.

The responsibility of that proposal was to gather and collate all of the research relating to mental health and alcoholism for Indian people. You might want to know that has been defunded.

Mr. **Gejdenson**. Defunded?

Mr. **Williams**. Defunded. We do have the data retrieval system there, but we have no money to operate it. So, I thought it might be something you would be interesting in taking——

Mr. **Gejdenson**. OK. Well, let us take a look at that.

Mr. **Williams**. It is on computer so it should not be that tricky to get.

Mr. **Gejdenson**. Thank you very much.

Cindy, do you want to start?

STATEMENT OF CINDY JONES, NURSING STUDENT, RAPID CITY SCHOOL OF NURSING, SOUTH DAKOTA

Ms. **Jones**. That is why I was late, because I was trying to decide if I should start or not.

I am a nursing student from Rapid City Regional School of Nursing. I am also one of those 150 students that receive an Indian health scholarship.

I am in my third year Rapid City Regional. I should have graduated May 17. I have not because I have 2 clinical days to make up. I have to do those 2 clinical days tomorrow and Thursday. That is why I was rather uncertain as to whether I wanted to present this today.

Could I ask for your advice?

Mr. **Gejdenson**. Sure.

Mr. **Jones**. Would you——

Mr. **Gejdenson**. Do you think what you are about to say could jeopardize——

Ms. **Jones**. My situation?

Mr. **Gejdenson**. Yes.

Ms. **Jones**. I think that it is—I have had Mr. Ellison look at this before I came over here, and so most of it is pretty general and I have not—my contentions are true. It is just that I have had a little difficulty. Students do not usually like to stay in the school of nursing. Most students when they are dropped out, just——

Mr. **Gejdenson**. Drop out.

Ms. **Jones**. Yes; I know why. And, I just, you know, in your opinion, would it be better to——

Mr. **Gejdenson**. I would go ahead.

Ms. **Jones** [continuing]. Wait until I finish the clinical days, or should I go ahead and present it.

Mr. **Gejdenson**. Well, do you want to talk to us privately afterwards.

Ms. **Jones**. Perhaps, that would be better.

Mr. **Gejdenson**. Fine. We would be happy to do that.

Ms. **Jones**. OK.

Mr. **Gejdenson**. Why not go ahead.

STATEMENT OF DR. JUD REANEY, PRIVATE BEHAVIORAL AND DEVELOPMENTAL PEDIATRICIAN AND ASSOCIATE CLINICAL PROFESSOR OF PEDIATRICS, UNIVERSITY OF SOUTH DAKOTA

Dr. **Reaney**. I would like to thank the committee for allowing me to be a walk in witness today.

Mr. **Gejdenson**. Please identify yourself.

Dr. **Reaney**. My name is Dr. Jud Reaney.

I am a private behavioral and developmental pediatrician and an associate clinical professor of pediatrics at the University of South Dakota.

Mr. **Gejdenson**. Where did you study?

Dr. **Reaney**. Pardon?

Mr. **Gejdenson**. Where did you study?

Dr. **Reaney**. Where did I study?

I got my medical degree from the University of California at San Francisco. I did my training in pediatrics and behavioral and developmental pediatrics at the University of Minnesota.

Following that, I was a general pediatrician at the Indian Health Service for 2½ years before beginning my specialized practice.

Presently, I serve as a consultant for the Aberdeen area Indian Health Service under contract. I am sort of a rare species in that I am paid by the Indian Health Service, and have a contract with them, but I work for the BIA. I am one of the few examples, I guess, of where the Indian Health Service and BIA do work together, and I am pleased to be in that position.

I am speaking today as a private consultant and a private citizen, and not representing any interest or view of the BIA or Indian Health Service.

My job for the Bureau of Indian Affairs is to evaluate children in the South Dakota area on numerous reservations and boarding schools, to certify them as emotionally disturbed for services under Public Law 94-142.

Children are sent to me. They have been identified by someone as having significant emotional and behavorial difficulties, and I evaluate them to see what the problem is.

My interest today in testifying here is the relationship that I see, the strong relationship I see between emotional disturbance of these children on reservations in Indian country, and alcohol and drug abuse.

When we think of emotional disturbance, I think a lot of times we think about emotional disturbance in children, in terms of childhood schizophrenia or autism. These children do not have these kind of inherited emotional problems. Rather, they have problems of chronic depression, anxiety, and conduct disturbances that are related to how they have been growing up, and their experiences in life.

Most of the children that I see who are diagnosed as having emotional disturbances, have accompanying alcohol and drug abuse problems.

I would assume it has been well documented by other witnesses, and I would confirm that these problems start at a very young age. I have heard about fourth, fifth, and sixth graders. Among the children that I see, it is not uncommon that these problems start at a much younger age, and they began using chemicals when they were preschoolers, or in kindergarten or first grade.

Now, granted, I am seeing a select population of children, but I think that they have a lot to teach us. These drug and alcohol problems in all cases, contribute to the children's emotional disturbance. In many cases, I believe, they are the real cause.

Very few of these children have had any alcohol or drug education. I guess I am proud to say as a pediatrician, that pediatrics has been in the vanguard of preventative medicine. We do a darn good job of getting kids diphtheria, tetanus, measles, mumps, and rubella vaccinations, polio vaccines. I think that we do a much less adequate job, in fact, have done an inadequate job in the area of preventative mental health.

I guess that I see House Resolution 1156, as a start in terms of a vaccination process for children of preventative mental health programs for children, Indian children, particularly in the area of drug and alcohol abuse.

We certainly learned in physical medicine, that preventative programs have a tremendous payoff. Certainly, not the least of that is the prevention of human suffering, and, in addition, we have cost savings.

In order for a child to receive adequate care for emotional disturbances, requires residential treatment. In this State, it costs about $34,000 a year. So, a child who has to be put in a residential situation in order to be treated for emotional disturbance, we pay $34,000 a year, which would come, generally, from institutional moneys from the Aberdeen area BIA office.

If you consider that that is multiplied many times over for all the other kinds of programs we do to catchup with problems of emotional disturbance, I think that anything we do to prevent emotional problems in children, will have definite cost savings, not to mention, of course, the savings in human suffering that these children have.

Presently, I am seeing many children are fourth generation alcoholics. It is not uncommon at all among a select group of children that are emotionally disturbed, to come from four generations of people who have had significant alcohol and drug problems.

Fetal alcohol syndrome and fetal alcohol effect, are epidemic among Indian children in this State. And they also contribute to mental limitations in children, to learning disabilities. And these children, are more likely, because of their fetal alcohol syndrome that they were born with because their mother ingested alcohol during pregnancy, to lead to emotional disturbance as well.

Teenage pregnancy, I believe, is also related to substance and alcohol abuse, and has contributed largely to a terrible situation of children raising children who again raise children, who again raise children.

Young adults who are not yet grown up, who are trying to raise children themselves. One of the most poignant examples that I was personally involved with, was a 16-year-old girl who delivered a child prematurely under the influence of K Mart gold spray paint. She delivered her baby into a toilet. That child is presently severely developmentally delayed, micro cephalic, that is, it has a small head and has not been able to be raised by that mother of course.

I would like to think that that was an isolated event, but I do not believe that it is. I think that the problems of chemical and alcohol abuse among our Indian children and teenagers, creates many such horror stories.

Once diagnosed as having emotional disturbance with chemical dependency, I usually have some recommendations to make about what services need to be provided to these children. And, in most instances, I find that there are either no or inadequate treatment programs that are available for children, and that there are inadequate alcohol and drug education programs in BIA schools, in 638 contract schools, and in public schools that have high numbers of Indian children.

Many emotionally disturbed children have been physically and sexually abused. They were not born with emotional disturbance, but they developed emotional disturbance after having been subjected to physical and sexual abuse. And, I must say, that many of these instances of physical and sexual abuse, were perpetrated by individuals who were under the influence of alcohol and chemicals.

In nearly all of the emotionally disturbed children that I see, have had significant grief and loss experiences. It is not uncommon to speak to a child who was sent to me because, supposedly they are emotionally disturbed, who have had two or three close relatives die within the last 1 or 2 years.

These are family deaths, which are most often alcohol related. Alcohol related suicides, homicides, motor vehicle accidents and alcohol caused disease related deaths.

Further, these children are growing up in homes that have significant incidents of divorce, family violence, and situations where the children have been abandoned.

It is no wonder to me that the children are having emotional problems. I sometimes am a little uncomfortable about giving these children labels of being emotionally disturbed.

Now, I am willing to do that if that is what is needed to get these children services under Public Law 94-142 or any other program. I am willing to do that. Certainly, these children have tremendous emotional needs. But, that is not where the——

Mr. **Gejdenson**. Responding to reality.

Dr. **Reaney**. That is not where the actions are, that is right. They are responding to the reality of their life situations which is horrible, and is related very much to problems with alcohol and drug abuse.

I would like, finally, just to commend the committee on their interest in this area. I think that House Resolution 1156, is an excellent start in this vaccination program.

Mr. **Gejdenson**. Thank you very much. You have once again reinforced my faith that the best doctors are pediatricians. That they care often the most. No offense to other doctors. And we thank you for your testimony.

Dr. **Reaney**. Thank you.

Mr. **Gejdenson**. Let me now thank my colleague and friend, Congressman Daschle, for inviting me and asking the committee to hold these hearings. I certainly will bring back to Chairman Udall, the impact on me, from both my visit to the reservation, and the testimony here today, which I think is as dramatic as any testimony that I have ever heard in my entire time in Congress.

For this country not to be responding adequately to a crisis of this proportion, is really an outrage. And, we will do everything within our power to see that there is some action taken. Tom.

Mr. **Daschle**. Sam, I think that I share everything that you have said. I feel that we have really given the momentum of this legislative effort, a real push this morning.

To every one of our witnesses, my sincere thanks for enlightening us, for sensitizing us to many of the difficulties that cannot be addressed in Washington without a better understanding in South Dakota and throughout the upper Midwest and on each and everyone of our reservations.

To Jud Reaney, a friend and a person who obviously cares a great deal, my sincere thanks for coming and taking his time. And especially, I want to thank the area directors. You know, it is difficult for them to be open, honest, to be candid, and to express themselves in a way that they did. And they did so with a tremendous amount of insight today, that is not oftentimes expressed and appreciated in Washington.

So, to all of you, my sincere thanks. I am very hopeful that the kind of effort that was put forth today, will lead to additional efforts, both elsewhere in the country, and, of course, for the hearing in Washington, to a culmination of legislation that will address this issue.

It is not going to go away. And unless we can deal with it more effectively, unless we can bring the tools that we have within our grasp, to address this problem far more effectively that we have in the past, we will all have failed. And that, to me, would be a tragedy, not only for the Indian people, but for all of America.

I think that can be prevented, and I think we have made a very positive first step today. And my thanks to each and every one of you and to the Indian—to the Interior Committee staff for their diligence in making it all happen.

Thank you Mr. Chairman.

Mr. GEJDENSON. Hearing adjourned.

[Whereupon, at 12 p.m., the subcommittee was adjourned.]

INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

FRIDAY, JUNE 14, 1985

House of Representatives,
Committee on Interior and Insular Affairs,
Albuquerque, NM.

The committee met, pursuant to notice, at 1:30 p.m., in the All Indian Pueblo Council, 1015 Indian School Road NW., Albuquerque, NM, Hon. Bill Richardson presiding.

Mr. Richardson. The Committee on Interior will come to order. I apologize for the delay in getting here.

I want to welcome my Native American and New Mexico constituents to a field hearing of the Committee on Interior. The committee is conducting hearings today on two bills, H.R. 1156 and H.R. 2624, to establish a comprehensive program in the area of Indian juvenile alcohol and drug abuse prevention.

H.R. 1156 is sponsored by Congressman Tom Daschle of South Dakota, and Congressman Doug Bereuter of Nebraska, who may be here shortly, or may not. We still are uncertain as to his final destination.

H.R. 2624 is sponsored by Congressman John McCain of Arizona.

The Committee on Interior will be traveling to Phoenix tomorrow to hold hearings on these two bills. These Members of Congress are to be commended for taking these initiatives to deal with this most important, critical problem on Indian reservations.

I am pleased to be able to bring the Committee on Interior here to Albuquerque to take Indian and other public testimony on these important bills.

I want to thank Congressman Udall, chairman of the committee, for approving these hearings, and Gilbert Pena, chairman of the All Indian Pueblo Council, for so generously offering this excellent facility for these hearings.

I don't think that there is any question that alcoholism and drug abuse on reservations is one of the most severe problems that Indian people have. This problem impacts most severely on our Indian young people. These are the people who will constitute the future of the Indian tribes. The lives of the Indian youth and the future of the Indian tribes will continue to be unacceptably impaired unless the United States shoulders its responsibility and seriously addresses this problem.

I want to give my own assurances, as a member of the Committee on Interior, that we are serious about enacting this legislation into law this year and seeing that it is effectively implemented by the administration.

We have a number of witnesses today. I would like to request that each witness submit their written comments for the record and limit their oral testimony to about 5 minutes to allow time for questions. In other words, your statements will be submitted for the record. They will be distributed to all members of the Interior Committee and made available to any Member of the House that wishes to peruse these hearings. And in addition to that, they will be summarized and kept in the complete file and permanent records of the Committee on Interior.

After the committee completes the witness list for these bills, it will proceed to take testimony on H.R. 1919, the BIA fiscal accountability bill. This bill, which is sponsored by Mr. Udall, Mr. McCain and myself, establishes statutory reporting and accounting requirements on the Bureau of Indian Affairs in order to make this Agency more accountable to the Indian tribes and to Congress for the expenditure of funds appropriated to it for Indian programs and services.

I would like to also recognize that accompanying me in this committee hearing is Greg Hautz, from the Committee on Interior, who serves Congressman McCain, who is an author of one of these bills that we are dealing with today and who we will be seeing tomorrow; and Frank Ducheneaux, a longtime member of the Interior Committee staff who has handled Indian affairs for many years.

I know many of you know Frank, and I can't underline the importance of the staff, the very fine staff that we have on the Interior Committee.

Before proceeding to our first witness, and without objection, let us have printed at this point in the hearing record, a copy of the bill, H.R. 2624.

[The bill, H.R. 2624, follows:]

99TH CONGRESS
1ST SESSION

H. R. 2624

To authorize programs for the treatment and prevention of drug and alcohol abuse among Indian juveniles.

IN THE HOUSE OF REPRESENTATIVES

MAY 23, 1985

Mr. MCCAIN (for himself, Mr. BARTON of Texas, Mr. BEREUTER, Mr. BLAZ, Mr. LAGOMARSINO, Mr. STRANG, Mr. UDALL, Mrs. VUCANOVICH, and Mr. YOUNG of Alaska) introduced the following bill; which was referred jointly to the Committees on Interior and Insular Affairs, Energy and Commerce, and Education and Labor

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A BILL

To authorize programs for the treatment and prevention of drug and alcohol abuse among Indian juveniles.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of Health and Human Services, hereinafter "Secretary", is authorized and directed to formulate a program for the treatment of Indian juvenile drug and alcohol abuse and coordinate such program within existing general programs for the treatment and control of alcoholism and drug abuse. Wherever possible, the Secretary is authorized to enter into an appropriate agreement with the Secretary of the Interior to share resources, including field facilities. Such Indian Juvenile Treatment Program should include post-treatment counseling. The Secretary is also authorized to allocate existing funds or personnel of a existing or new program to designated "crisis areas" on an emergency basis, as determined in section 5 of this Act.

SEC. 2. The Secretary shall establish an Office of Indian Juvenile Alcohol and Drug Abuse within the Alcohol, Drug Abuse and Mental Health Administration which shall be responsible for integrating the provisions of the first section of this Act with the programs and authorities of the Department in the field of alcohol and drug abuse. The Office shall have assigned to it a number of full-time equivalent positions, which shall not number less than eight, and such other positions as the Secretary deems necessary. Through this Office the Secretary is directed to consult with tribes concerning implementation of the programs authorized by this Act.

SEC. 3. (a) The Secretary shall within one hundred and eighty days of the date of enactment of this Act, enter into an agreement with the Secretaries of the Interior and of Education to coordinate their Departments efforts and programs related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coordination of available resources and programs to address and treat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary shall publish such agreement in the Federal Register within thirty days after an agreement has been entered into pursuant to this subsection.

(b) The Secretary, in consultation and in cooperation with the Secretaries of the Interior and of Education, shall develop a program to provide training in—

(1) the identification of juvenile alcohol and drug abusers; and

(2) prevent education (including drug and alcohol abuse), health promotion and disease prevention;

(3) counseling techniques on juvenile alcohol and drug abuse.

Such training shall be made available to elementary and secondary teachers and counselors—

(A) in schools operating by the Secretary of the Interior;

(B) in schools operated under contract with the Secretary of the Interior; and

(C) in public schools on or near Indian reservations (including public schools in Oklahoma, Alaska, and other States with significant numbers of Indian students).

The Secretary may provide such training either directly or through contract with qualified private or public entities.

(c) The Secretary of the Interior, in consultation and in cooperation with the Secretaries of Education and of Health and Human Services, shall review existing materials on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse, and shall make available the results of such review to the schools described in subsection (b).

(d) The Secretary of the Interior shall require Bureau of Indian Affairs schools and schools operated under contract pursuant to the Indian Self-Determination and Education Assistance Act (Public Law 93-638) to provide a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve. Schools providing programs of instruction under this subsection are encouraged to emphasize family participation in the programs.

(e) For the purpose of implementing subsection (b) there is authorized to be appropriated $1,500,000 for each of the fiscal years 1986, 1987, 1988, and 1989.

SEC. 4. (a) Any training program for community health representatives funded under the Act of November 2, 1921 (25 U.S.C. 13) shall include training on the problems of alcohol and drug abuse and shall include instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome.

(b)(1) The Secretary, in consultation with the Secretary of the Interior, shall either directly or through contract, make available training on the problems of alcohol and drug abuse, including instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome to—

(A) the Bureau of Indian Affairs Superintendent of Education (or his designee);

(B) the Bureau of Indian Affairs Agency Superintendent (or his designees);

(C) Indian Health Service service unit directors;

(D) Bureau of Indian Affairs social workers;

(E) Indian Health Service doctors, nurses, nurse's aides, and paramedical personnel;

(F) Bureau of Indian Affairs school personnel;

(G) personnel of schools operated under contract under the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(2) The Secretary shall also make available, upon request, the training described in paragraph (1) to—

(A) Federally recognized tribal organizations and personnel, including but not limited to tribal council members, tribal court judges, and tribal law enforcement officials.

(B) Administrators of the Women, Infants and Children Program (WIC), operated by the Department of Agriculture; and

(C) Personnel of public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and other States with significant numbers of Indian students;

(c) The Secretary shall, upon request, provide certification to any person who completes training under this section, for the purpose of obtaining academic credit or certification at any post-secondary educational institution.

Sec. 5. The Secretary shall, within one year of the date of enactment of this Act, conduct a study to determine—

(1) the size of the juvenile Indian population in need of residential alcohol and drug abuse treatment;

(2) the definition of a "crisis area" in which the need for treatment is critical and immediate;

(3) where other programs for emergency and long-term treatment should be located; and

(4) the cost of providing such treatment.

Sec. 6. The Secretary is authorized to enter into an agreement for the operation of any program authorized under this Act, with a "participating" tribe or tribal organization. A participating tribe or tribal organization is one that has notified the Secretary of its willingness to operate a program and to provide 25 per centum of the costs of such a program, either through funding, facilities, or in-kind services.

SEC. 7. There is authorized to be appropriated such sums as the Secretary and Congress determine to be necessary to carry out the provisions of this Act.

Mr. **Richardson**. We will now proceed with our first witness Mr. Gilbert Pena, the chairman of the All Indian Pueblo Council. He will be accompanied by Mr. Joe Jojola, director of the AIPC Alcoholism Program, and Mr. Tom Lujan, from the Taos Pueblo. In addition to that, Governor Alvino Lucero of Isleta is representing the southern pueblos.

Gentlemen, if you could make your way to the podium, we could proceed. We will start with Mr. Pena.

Mr. **Richardson**. Mr. Pena, please proceed.

[Prepared statements of Gilbert Pena, Alvino Lucero, and Joe Jojola may be found in appendix II.]

PANEL CONSISTING OF GILBERT PENA, CHAIRMAN, ALL INDIAN PUEBLO COUNCIL; JOE JOJOLA, DIRECTOR OF THE ALL INDIAN PUEBLO COUNCIL ALCOHOLISM PROGRAM; TOM LUJAN, TAOS PUEBLO; AND ALVINO LUCERO, GOVERNOR, PUEBLO OF ISLETA

Mr. **Pena**. Mr. Chairman, welcome to your homefront. Thank you for your concern. Hopefully, with the implementation of this piece of legislation, we can collectively begin to address a problem that threatens the course of our future.

There is an obvious need to develop new and innovative methods of prevention and education to deter the use of alcohol and drug abuse among our young people. However, to begin to address this problem, we need the resources to identify the magnitude of the problem and formulate concrete recommendations that can be implemented.

Mr. Chairman, I would like to defer any further statements on our testimony to the director of our Alcoholism Program, but before we do that, I would like to extend the courtesy to Governor Alvino Lucero to first make his comments.

Mr. **Lucero**. Thank you very much, Mr. Chairman. I appreciate the opportunity to be here this afternoon. I won't go into the written statement that I have here, but I will just sort of summarize it and the needs on behalf of the Indian Juvenile Alcohol and Drug Abuse Prevention Act.

We know that we have many, many of these within our communities that are faced with drug and alcohol abuse. We have been trying to work on this problem for many years. However, I don't believe that we have worked on the most important thing, and that is a preventive type of a system.

We start working with our alcoholism, in my estimation, when it is too late. We have programs within our tribes, but the initial thing that I would like to see is a preventive type of system for our use.

One of the major causes of death, of course, is accidents that are related to alcohol. The other is cirrhosis of the liver, causing death at about five times the national average. Suicide, that also has a bearing on alcoholism.

So these are some of the things that we are faced with within the Indian community, and I believe those are the things that we need to work at and prevent.

Now we have statistics in our—I picked up statistics from my own pueblo, and they are written down for the committee and you, Congressman, to take a look at so that you will know exactly what we are talking about.

I have testified on behalf of the Southern Pueblos Governors, which I also am the chairman of, and I have talked with the rest of the Governors, and they know that this is a problem throughout, not only in the Pueblo of Isleta, but throughout.

So with this, Mr. Richardson, I know that you have many other persons that need to testify, so I will let Mr. Jojola make his statement.

Thank you very much.

Mr. RICHARDSON. Thank you, Governor.

Mr. JOJOLA. Before I start, I would like to relate a short anecdote.

It seems that a non-Indian once asked an Indian from one of the pueblos what course of action would be taken if, for example, an old house located in the village was causing illness and death to those children who entered it, but could not be destroyed because of historical reasons.

The Indian replied, "We would warn the parents and children about the illness and tell them not to enter the house or even play around it."

He was then asked what the tribe would do if the children kept entering the old house out of curiosity or whatever reason they may have. The Indian replied again, "We would probably build a fence around it and place warning signs to keep the children out."

Again he was asked what the tribe would do if the children ignored the fence and warnings from the parents. The Indian replied, "We would probably have to place a 24-hour guard around it to ensure that the kids would not enter or play around the house."

To that, the non-Indian asked, "Alcoholism is an illness and is killing many of the young people who use it. Are you taking the same measures with alcoholism in preventing an illness or death as you would have done with the old house?"

In reference to the anecdote I have just related to you, perhaps many of us have assumed that merely warning and lecturing about the dangers of alcohol and drugs will deter them from experimentation and eventual use or abuse. We perceive that what we say or print are sufficient means of prevention.

The present rate of alcoholism, alcohol-related morbidity, and alcohol-related deaths among Native Americans indicates that there is a need to expand on the present treatment modalities, including education and prevention. Until recently, we have spent much of our time and resources treating the chronic and end-stage alcoholics, including patients victimized by alcoholics, and have done little in terms of prevention and education. I sincerely believe that we are long overdue in developing effective preventive models that will produce measurable results.

The Bureau of Indian Affairs and the Indian Health Service have at their disposal documents and data to support the fact that alcohol and drug use among the Indians begin at a very early age, perhaps as young as age 10. Reported incidents on juveline delinquency, behavioral problems in schools and homes and the treatment of injuries are directly related to substance abuse. A conjecture can be made that the possibility of young abusers becoming addicted to alcohol and drugs is extremely high and that the problems manifest themselves in catastrophic consequences.

In relation to this, the Census Bureau report of 1980 relates that the median age for Native Americans in New Mexico is 20.2 years of age, while the median age is about 31 years. There appears to be a correlation between the percent of reported alcohol-related, criminal offenses committed by individuals within the median age group. The assumption is that the younger the population, the higher the percent of alcohol-related offenses.

This information and the testimony presented by others here today will undoubtedly impress upon you the need to develop new and innovative methods of prevention and education specifically addressing the needs of Native American youth.

I am pleased to know that bill, the Juvenile Indian Alcohol and Drug Abuse Prevention Act, and its intended purposes will provide us with the mechanisms and the resources needed to enhance the present efforts in education, prevention, and treatment of our youth.

This bill will also provide a positive direction for the Bureau of Indian Affairs, the Indian Health Service, and the tribal governments to work collectively in minimizing and curtailing the problems of alcohol and substance abuse. Perhaps now we can figuratively build fences and place 24-hour guards in the protection of our young people.

I would like to take this opportunity at this time to address some of the issues and make recommendations regarding this bill. It is without question that the overall intent of this bill is both timely and worthwhile and, accordingly, is strongly supported. However, some issues need to be resolved and some of the recommendations offered here should be closely considered by legislators.

First, no concise methodology has, to our knowledge, been formulated regarding the identification and screening of those Indian juveniles that might be potential offenders and that would need the services outlined in the different titles of this bill. Accordingly, the development of such identification criteria must be first formulated, preferably by existing service providers familiar with the extent and pervasiveness of the problem.

Second, the need to accurately document the number of individuals needing such services is self-explanatory in maximizing the impact of available funds. Accordingly, data should be compiled that could outline the number and locations to be impacted and the severity of the problem with specificity.

Third, documentation on the successes and problem areas that exist within current programs that address this issue should also be solicited. Accordingly, a network should be established of existing service providers and the effectiveness of their current methodologies, shared with others for possible duplication when applicable.

Fourth, the cooperation through involvement of tribal governances should be elicited. No other entity but a tribe's own leadership is as well aware of the devastation caused by drug and alcohol abuse among its constituency. Accordingly, tribal leaders should be involved in the direct formulation of service provisions that would impact on their respective use of populations.

Fifth, the development of separate curricula, to be applied to both juveniles and as training tools for staff, administrative, and law enforcement personnel, needs to occur. Many excellent units already exist that could render a substantial positive impact on this issue. Accordingly, it is strongly recommended that entities wishing to address this issue first develop or propose a comprehensive curriculum that would be applied to both juveniles and service providers and that would stress the overall intent of prevention as a viable tool in curbing drug and alcohol abuse.

I am going to hold this short, and I will finish it up with the last part here.

Given the extremely important need to base all rehabilitative programs on sound and current data, we strongly suggest that through the auspices of the Albuquerque Area Indian Health Service, the All Indian Pueblo Council, be contracted to conduct a study as proposed under title V of this bill, a study to be conducted by the all Indian Pueblo Council's Pueblo Health Training and Development Program.

This committee should be aware that presently both the Bureau of Indian Affairs and the Indian Health Service have the resources available which could easily sponsor this proposed study. It is recommended that these agencies, at the local level, make these resources available to the All Indian Pueblo Council as soon as possible.

It is strongly suggested that the results yielded by this study can facilitate the enactment of this bill by underscoring the severity and prevalance of drug and alcohol abuse among pueblo youths. Given the excellent record of the All Indian Pueblo Council's ability to provide pertinent data in a timely fashion, this committee's endorsement of such a study is strongly recommended.

Again, let me thank this committee for giving me the opportunity to partake in this hearing.

Thank you.

Mr. **Richardson**. Thank you very much, Mr. Jojola, Mr. Pena, and Governor.

Let me first of all commend all of you for the work you have done on this issue. I think it was only 2 weeks ago that we held a hearing in Gallup, NM, through the Senate Indian Affairs Committee, dealing with the same kind of preventive programs, although on a larger scale. And at that hearing I think it was easy to conclude that alcoholism is the No. 1 killer of Native Americans, and if we can develop a substance abuse program, juvenile alcohol program, that that's the start to make.

And, Mr. Pena, I also want to commend you for your testimony in Congress yesterday—I know we are talking about separate issues—on the eagle feathers and the Forest Service. You are a busy man, and I want to commend you for representing your people very well.

Let me ask what I hope to be a constructive question.

Mr. Jojola, Mr. Pena, and Governor, you have all endorsed the two bills, H.R. 1156 and H.R. 2624, and I hear a lot of talk about the need for more documentation, more data base, to increase the conciseness of the methodology and improve the curriculum. I guess the nuts and bolts of my questions is, when we talk about new juvenile preventive treatment programs, what exactly are we talking about?

I was very impressed in Gallup with the description of a program that the San Juan Pueblo had that was a combination of treatment, and it was like a work study program, training and treatment at the same time, simultaneously. And I wonder if that is the kind of feature that you are incorporating into this new talk of new curriculum.

I guess what I am trying to get at is, we can go ahead and improve all the coordination of all the agencies involved, and God knows we need to do that. All the various pueblos, et cetera, need to exchange information better. But what exactly are we talking about in terms of that preventive treatment?

Mr. LUCERO. I believe the preventive type of treatment that I am talking about or recommending is that today the youth within our pueblos, as I mentioned, have drug and alcohol problems. We have no programs to educate them as to the consequences of drugs and alcohol. We don't have youth counselors; there are none. We are faced with that.

They come and appear before the tribal courts. In many instances they have nowhere to refer this youth, the juveniles. There is no system within the pueblos to house them, to educate them, to help them, to prevent them from getting involved with alcohol.

And we don't have any places for educational materials. One of my recommendations is that some type of—like one of the other alcohol programs that we have is a halfway house, I believe, in Santa Clara for adults. These are some of the systems, Mr. Chairman, that we are lacking. There are no centrally located structures for them to be housed in, and that is what I am making reference to.

Mr. PENA. Mr. Chairman, I agree wholeheartedly with Governor Lucero. If I may take his statement a little further, I think most of the alcoholism programs, in fact, are identified as programs for adult males. In fact, the female alcoholic is not being sufficiently addressed in my mind with treatment centers available for that type of treatment of females.

But I guess with the youth of our pueblos, there are essentially no training programs and there are essentially no programs that help and that detox and for further treatment of those individuals. You can't very well take a 15-year-old or a 16-year-old and put them in a halfway house which is primarily occupied by adult alcoholics.

I think that is a problem that we have with some of the alcoholism programs that we have in place.

In addition to that, at the present time no where in the North, or the South, or as far West as Zuni are there any holding facilities for the treatment of youths have gone into the very chronic stages. We have youths that may become disorderly, and consequently at the same time they are incarcerated in jails that are primarily made for the adult population.

The other problem, Mr. Chairman, is that we may start a program this year as far as alcoholism and the treatment of youth.

However, I think an important thing is that needs to be continued adequate funding to maintain and get those programs on the road.

Mr. **Jojola**. Mr. Chairman, I can't really honestly tell you what a treatment prevention program is. Everybody has his own or her own concept of what excellent prevention is. What we are merely suggesting here is that perhaps what works in one area should be subject to constant scrutiny which can be operable in other areas.

I know that the Indian population itself has an idea of what prevention is. To them in many areas it is treatment or background training in traditionalism. We do have in my program a youth program that takes kids on an Outward Bound Program, takes them up in the mountains, and we take them for a whole week. And this is part of prevention, in our minds.

For other people it is education day and night. On the other hand, you have summer recreation programs to give the youths something to do to keep their minds occupied. That is a form of prevention.

So, I cannot tell you what types of prevention work best in different areas, but I do appreciate your question. And perhaps from this bill we can answer those kinds of questions and be more specific.

Mr. **Richardson**. I guess one of the things that I am getting at is that, in reading some of the data prepared by the committee staff, one of the things that was most glaring was the lack of documentation on what programs have worked. Now, I sense from what you said that we do have some programs that the pueblos are using that are working, but we still need that data collection so that we don't repeat the mistakes of the past.

I have a question that I would like to ask, and maybe you aren't the people to answer it because it is a very sociological question, and that is this: I notice a huge scale of juvenile alcohol problems among Indian males and Indian youth, but a disproportionately lower proportion for Indian females and Indian youth.

Why is that? Is that a cultural—is that a sociological phenomenon? And it's dramatically lower, in fact, lower among Indian women than the average white female. Is there any data as to why this is the case? Are we talking about prevention programs then, if that statistic is valid, that are very strictly oriented toward the male?

Mr. **Jojola**. Treatment has historically been directed at the male until recently. We have started putting some of our emphasis on working with the female. The fetal alcoholism syndrome program here in Albuquerque. Now, I sense from what you said that we do have some programs that the pueblos are using that are working, but we still need that data collection so that we don't repeat the mistakes of the past.

These statistics, we do have a large percentage of females with problems, but we don't have documentation to prove the numbers or say that a higher percentage of women do have a problem with that. But I believe that we do have a problem and that it is a higher percent for women.

Mr. **Richardson**. Well, the data that was prepared for me showed—this was for the whole Indian population in the country, but it may be different here in New Mexico. All I am saying is this: that if we are going to proceed with some new programs and we need this, that we ensure, first of all, that they are programs that are efficiently run, that are funded properly, obviously within these budget limitations.

But I sense very much that the old IHS methods that have been used—I think it was dramatically evident in the Gallup area with the Navajo population—that somehow the treatment isn't getting to the people. The treatment is not being sometimes properly administered because of funding problems and other things, I think a lack of real knowledge on how we should proceed. I think this is the case with alcoholism problems, in general.

But it seems to me that perhaps a bill like this would at least bring the best minds together, and the best programs together, and adopt a national policy which, I think if you started it at a preventive age, at an early age, that you could make some progress. But otherwise I think that this is the biggest killer in the Indian nation, above everything else, and we just seem to be flapping away at it ineffectively.

Mr. Jojola. I think you have addressed that to some degree in parts of your bill with the Indian Health Service.

What we have recommended is that not only the CHR's be maintained, we have recommended that all essential staff at the hospitals be maintained. I think perhaps that is another positive direction we can take. They can also identify the very early stages of alcoholism. They treat the accidents, they treat the suicide attempts, they treat all the injuries resulting from alcoholism, so they are knowledgeable of alcoholism problems. That could be another preventive measure and a very good one.

Mr. Richardson. This will be the last question I make to this panel, and I am going to make it to Mr. Pena, since he is the titular head of the All Indian Pueblo Council, and that is, you used the word "methodology." I am talking now about the bureaucratic methodology of how do we implement these programs? Is IHS the vehicle?

I think Mr. Jojola mentioned an AIPC study. Are you talking about more direct grants to the pueblos or to the AIPC and bypassing some of the established mechanisms? Should we do more contracting out to private sources? What should we do?

We know the BIA is a bureaucratic nightmare, with all due respect to the good people that work there, but what is the vehicle? If we are going to start new and make an investment of millions of dollars, what do we need to do differently to improve the efficiency of these programs, bureaucratically?

Mr. Pena. I think, Mr. Congressman, that the first thing we ought to do is cut the bureaucracy. We have been attempting for many, many years to try to streamline the bureaucracy, but it seems like we have never progressed very well in that arena. I would suggest, and you know what I would probably suggest is direct funding to pueblos, nations, and pueblo groups themselves to carry on the programs that need to be carried on.

Mr. Richardson. Bypassing whom?

Mr. Pena. Bypassing the Indian Health Service, the BIA, or what have you, direct funding. The policy of this administration is Government-to-Government relationships, and you know, too many times that is not practiced.

Mr. **Richardson**. Governor.

Mr. **Lucero**. Mr. Chairman, I believe that you asked that same question in Gallup a couple weeks back, and I think I answered it the same way.

Mr. **Richardson**. Well, it wasn't very clear. You know, today Gilbert was very clear, but do you concur with that approach?

Mr. **Lucero**. I concur with that, Mr. Chairman.

Mr. **Richardson**. You are proposing a radical departure of policy. I hope you realize that.

Mr. **Lucero**. Well, perhaps we have some reasons behind that, Mr. Chairman. And one of the reasons is, when the Federal dollars come either to the Bureau or to the Indian Health Service—as a matter of fact, if we were to get 1919, some of this would probably come about. But that is, where does the funding really go?

There are many times when funds are made available, but by the time they reach the Indian people within the tribes, it really doesn't amount to anything to start a program with. And I realize that we have to abide by some types of rules and regulations, and I think that the tribes are willing to adhere to that type of thing.

But I think if the Federal Government would give us an opportunity to put programs together, because I do believe we have professional people within each tribe to make studies. And I have statistics with my testimony here as to what happens to the male, the female, youth, and otherwise. I believe that those types of systems, Mr. Chairman, will work. So I agree and I am with Mr. Pena.

Mr. **Richardson**. I know later in the hearing we want to get into whether there should be a difference in the approach toward urban Indians, as opposed to reservation Indians, on the juvenile alcohol issue. Is there anything any of you wish to make on that, very briefly, before we proceed to the next witnesses in terms of differences and emphasis and approach, or do you want to leave it to the technicians?

All right. Thank you very much.

Mr. **Pena**. I just want to say one additional thing.

I know that Governor Lucero referred to testimony on 1919. Although we are on the witness list, we will not be giving any testimony because we have not had sufficient time to consult with the rest of the tribes. And for that reason, we would like to respectfully request that we be omitted from that witness list until such time that we can get better information on the bill itself.

Mr. **Richardson**. Yes; without objection, although I will stress to you the importance of getting your input, because I am one of the coauthors of this bill, and it deals with this whole issue of BIA accountability, your self-government contracts that are at the nub of some of the concerns that you have. So I will certainly——

Mr. **Pena**. We wholeheartedly agree with the importance of the bill, Congressman.

Mr. **Richardson**. The hearing record will be kept open for you to submit these replies. I would like to do it within the next 10 days so that we can move ahead with the legislation, because the legislative year is getting shorter and shorter and I want to address some of these issues in this session of Congress.

Mr. **Pena**. Thank you.

Mr. **Richardson**. Thank you, Mr. Pena.

Mr. **Richardson**. Our next witness is Mr. Stanley Paytiamo, representing Pueblo De Acoma.

Mr. Paytiamo, welcome to the committee. Your statement will be made a part of the record. I would like to ask you to summarize your statement so that we can proceed.

[Prepared statement of Merle L. Garcia may be found in appendix II.]

STATEMENT OF STANLEY PAYTIAMO, HUMAN SERVICES ADMINISTRATOR, PUEBLO DE ACOMA

Mr. **Paytiamo**. Good afternoon, Mr. Richardson. My name is Stanley Paytiamo. I am from the Pueblo De Acoma. I am representing the Governor's office. You have our prepared statement, so I will just make a brief summary.

We support the juvenile alcoholism bill. As in the past, we have indicated and the Indian Health Service has indicated and has put alcoholism as the No. 1 priority, but it seems that no funds have ever been made available. I think that if this bill is really supposed to do what it is supposed to do, there should be some adequate funding to the locally recognized Indian tribes.

And then also it is the No. 1 killer on the Indian reservations. Every accident that we have on record, they are all alcohol related. And one of the other things that is needed is a survey of—and we have done one at Acoma back in 1977—as to substance abuse all the way from 6-year-olds on up, and there are still additional surveys that need to be done in this area.

And also I think that not only the juveniles have that problem. I think all age categories have this alcohol problem, especially also the senior citizens.

I attended a meeting in Miami of the National Tribal Chairmen's Association, where in the central office one of the department heads indicated that the services for the elderly have a very low priority, and he indicated that the youths should have a high priority. I don't believe that should be the case. I think that the elderly and the juveniles all have equal needs, especially in the area of alcholism.

That is the extent of my summary. You have my prepared statement, and if you have any questions, I will be glad to answer them.

And also in the area of the BIA accountability, we have our prepared statement also. The Pueblo De Acoma supports this bill. I think it will make the Bureau of Indian Affairs much more accountable than in the past.

One example that we may give is that there was a certain amount that the ADP was short, and that the services programs had to suffer because they had to bail out the ADP. That is all I have to say, and if there are any questions, I will be glad to answer them.

Mr. **Richardson**. I just have one question. You said you do have a prepared statement on the BIA accountability——

Mr. **Paytiamo**. You have that.

Mr. **Richardson** [continuing]. That you wish to submit for the record?

Mr. **Paytiamo**. Yes.

[EDITOR'S NOTE.—At time of printing the above-mentioned statement had not yet been supplied. When received, that material will be placed in the committee files of today's hearing.]

Mr. RICHARDSON. You support the act?

Mr. PAYTIAMO. Yes, we support the act.

Mr. RICHARDSON. I guess the question that I would like to ask relating to Acoma would be is there any association between the closing of the mines in that area and the high incidence of alcoholism? Has that contributed to further problems with perhaps the use of some of those miners?

Mr. PAYTIAMO. Yes, we do, because of frustration within the family. And the unemployment rate right now is 78 percent, and 75 percent of our men were working in the mines.

Mr. RICHARDSON. Seventy-eight percent unemployment?

Mr. PAYTIAMO. Seventy-eight percent unemployment, and 75 percent of our people were in the mines, were employed in the grants area.

Mr. RICHARDSON. That is a dramatic statistic.

Mr. PAYTIAMO. I think that it is pretty high, although the various agencies do joke about it because they think that we are lying. They can't believe that 78 percent is what we have, whereas the national, I think, is something like 6 percent.

Mr. RICHARDSON. Do you support what Mr. Pena mentioned, the direct funding to you, as opposed to Federal agencies like the IHS?

Mr. PAYTIAMO. I think indirect costs are the relative goal. In contacting the committee out at ACL Hospital, there is a problem with indirect costs. I think that if there are any programs affecting the area of alcoholism, they should be adequately funded on indirect costs.

Mr. RICHARDSON. One last question that I would like to ask you. You mentioned that the orientation should be equal among the elderly and youth in terms of any prevention programs. If that is the case, do you think that the emphasis on prevention should be more of a family counseling kind of orientation and funding programs?

Mr. PAYTIAMO. I believe so. In fact, we have put together a preventive health plan where we do not ask for a lot of construction, like hospitals or clinics. In fact, we have a high priority on prevention, and especially I think in the area of family counseling is where we really need it, because that is where most of the bigger problems are.

Mr. RICHARDSON. Well, it is reaching a point where we can't afford those hospitals and those infrastructure facilities anymore, and I think your approach is a correct one.

Mr. PAYTIAMO. Our approach is more toward prevention. In fact, I have not seen very many Indian films. We have "A Bitter Wind," and there are several that I cannot recall, but I have seen "A Bitter Wind" a number of times, and each time I see it I learn something new from it. I think that if we—especially the youth. In fact, we did that one time at home. A group from the University of Utah came down over a weekend and they showed the children how to use video equipent, and they spent the rest of the week putting their own film together.

I think that if the youth could put something like that together, I think that they can maybe break the alcoholism down, because I think the youths all seem to want to—when I was young, I was doing the same thing they are doing right now. So that must be something that we all go through.

I think that if the youths could put a film together and others could see it, it would solve more of their problems, instead of having adults trying to tell the youths what to do. I think if the youths learn this from their own peers, I think it might be very effective.

Mr. **Richardson**. Thank you very much for a very good statement, and your full statement will be made a part of the record.

Thank you very much for appearing before the committee.

Our next witness is from the Navajo Nation, Ms. Gardenia King, the director of the Navajo National Alcoholism Program. She is accompanied by Augusta Vea, a student from Chinle, AZ, and Ophelia Barber, a student from Shiprock, NM.

[Prepared statement of Gardenia King may be found in appendix II.]

Mr. **Richardson**. I want to welcome the three witnesses. Your statement will be made fully a part of the record. I once again ask you to summarize, and I hope we can hear from the students, the two young ladies with you also.

Please proceed.

PANEL CONSISTING OF GARDENIA KING, DIRECTOR, NAVAJO NATION ALCOHOLISM PROGRAM; AUGUSTA VEA, STUDENT, CHINLE, AZ; AND OPHELIA BARBER, STUDENT, SHIPROCK, NM

Ms. **King**. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to be here before you to present testimony on behalf of the Navajo Nation. As mentioned, we have brought two youths to testify——

Mr. **Richardson**. Could you speak a little louder? Can you hear her back there? Everyone says yes. I must be going deaf. I apologize.

Ms. **King**. We appreciate Congressman Bereuter's and Congressman Daschle's efforts contained in House Resolution 1156. We also appreciate your support and your continued support in advocating for the Navajo people, the Indian people.

It has been repeated that alcoholism is a leading health problem among Indian people. We are finding now that within our Navajo youths, it affects 52 percent on up. There are very limited services available, especially when applied to the Navajo population.

We have recently opened at Chinle a juvenile adolescent treatment facility which is a short-term treatment facility in Chinle, very new, 2 weeks old. And the referrals right now are already on a waiting list.

We have a youth education substance abuse program that was primarily developed as part of our curriculum. There has been the development of the alcohol, drug, and substance abuse program for fifth and sixth grade students which is now being implemented into the curriculum of the schools throughout the reservation.

We also have a Tuba City Adolescent Substance Abuse Program that is primarily working with the Indian population, and there are limited resources and limited staff available. We are beginning to see the results of this program after having been on the reservation for a period of over 3 years.

The prevention programs are fairly new to the Navajo. We have concentrated on treatment and intervention. We are now taking a multifaceted approach in providing services to the population. We are integrating prevention, intervention, treatment, and hopefully with the help, assistance, and cooperation of the Indian Health Service, medical services, medical detox services, for those in need of medical treatment.

It is a conservative estimate to say that at least 25 percent of our Navajo youth are experiencing substance abuse. Because of the cultural instability and assimilation that our tribe has experienced over the past decades, we are beginning to realize that a lot of our youths are facing a loss of identity, where their self-image, their self-esteem, and motivation is not at a level where it should be. These are some of the things that we would like to concentrate and focus on.

We view this proposed legislation as part of the trust responsibility. Eligibility for such benefits must be determined on a government-to-government basis, as defined by the Snyder Act, the Health Improvement Act, and the Indian Self-Determination Act. We have eight issues that we are making recommendations on relative to House Resolution 1156.

We would like to recommend that the tribes be involved with reference to the Indian Health Service and the Bureau of Indian Affairs. One of the recommendations that we have is that language be written to assure that tribal governments have pronounced authority, not only in the development, but in the implementation of this bill.

An example of this recommendation has been set with the Indian Child Welfare Act that was passed in 1978. In that act it stated, "Let's do it the way that the Indian people and tribal traditions mandate. Let's recognize tribal sovereignty." This I ask you to consider.

We are recommending that more emphasis be placed on the family. The bill, as written, excludes family.

We are also recommending that in lieu of the term "juvenile," "adolescent" be used, and that the adolescent be viewed and treated as a member of the family and not as an individual.

Training issues: We are urging that in addition to the list of resources, families be included in this training, not only the families of the individuals, but also those families that are in the foster care home environment.

Access to recreational facilities is needed year round and not only during the summer months. So we would like that to be extended through the 12 months and not just the 3 summer months.

We are recommending that the law enforcement agencies make referrals in those cases that require medical attention, that they have access to a medical facility. As written, it appears that the law enforcement officers will be referring all juveniles to either a shelter or to a treatment facility. And in most cases, detox up front is more important.

We are also asking that language be written and clarified and specified as to whether the individual, the adolescent being referred, was involved in criminal activity or was he just under the influence? We need a specific reference and clarification on that.

We are recommending that the Indian Health Service facilities provide access or provide beds for treatment for these adolescents, indeed, and that this be included in their planning for additional health facilities and additional facilities.

The Navajo traditional ways recognize the importance of taking measures to prevent illness and promote healthy lifestyles. We have within our culture a goal of healthy living, which is the essence of harmony. And with that, we believe that harmony is health, harmony is beauty, harmony is happiness.

That is my presentation. If you have any questions that I can answer——

Mr. **Richardson**. Would the two young women like to make a brief statement?

Ms. **King**. Yes. I would like to introduce Augusta Vea, from Ganado, AZ.

Ms. **Vea**. Good afternoon, Mr. Chairman. My name is Augusta Vea and I am from Ganado, AZ. I thank you for the opportunity to testify about the alcohol and drug problems that we in the Navajo Nation are facing. I come before you today to share a part of my life experience with you that relates to what I have experienced. I have been exposed to an environment where alcoholism——

Mr. **Richardson**. Excuse me for interrupting. This time I know it is not my deafness because somebody else sent me a little signal. We want you to speak up a little bit. Hold the front of the mike right in front of you. Don't be shy. Nobody up here is that important. Just go ahead and say what you have to say.

Ms. **Vea**. Do you want me to start all over again?

Mr. **Richardson**. Yes, start all over. You can use the channel 4 mike.

Ms. **Vea**. Good afternoon, Mr. Chairman. My name is Augusta Vea, and I am from Ganado, AZ. I thank you for the opportunity to testify about the alcohol and drug problems that we, the Navajo youths, are facing. I come before you today to share a part of my life experience with you that relates to the bill being heard today.

I have been exposed to an environment where alcohol and drug use was minimal, and that was in Utah. When I moved back to the reservation, I found that I could not make friends unless I, too, used alcohol and drugs. I got caught for my actions.

From this experience I can tell you that parents and teachers need to teach us about alcohol and drugs. Communities have to have facilities where youths can pass time without the use of alcohol and drugs.

I went to school in Utah for 5 years and I lost my language. I have problems now in communicating with my grandmother. This bothers both me and my grandma. Other youths are having the same problem, the problem of not being a part of our traditional way of life, the way our grandparents were taught.

Mr. **Richardson**. Thank you very much.

Ms. **King**. Mr. Chairman, I would like to introduce Ophelia Barber of the Sanostee chapter.

Ms. **Barber**. Good afternoon, Congressman Bill Richardson and members of the committee.

My name is Ophelia Barber, and I am a Navajo from Sanostee, NM. I graduated last month from high school. I am here today to testify and represent the Indian youths and the problems that we are now facing not only on the reservation, but throughout the United States, in the use and abuse of alcohol and drugs.

We know that alcohol is the most widely used drug and should be considered first in any discussion of drug use and abuse.

Preventing drug abuse: We know that people get on drugs mainly to get a high, maybe because of peer pressure or to hurt their parents because they are not getting enough attention. As different as these reasons seem, there is one common thread: to be something different than what they are, and drugs is sometimes the best way to change. But they don't realize that drugs don't solve problems. They just postpone them and make matters worse.

Preventing drug abuse may be as simple as having something better to do than to do drugs. We need facilities for use, such as recreational facilities. Afterschool activities, like clubs, organizations, or sports are good alternatives to drugs.

Schools should introduce at the elementary level the causes and effects of drugs and alcohol. Not only the students, but the parents should get involved.

You, being our respected leader, this is where we need your every effort and strong support financially to bring this bill to a reality.

Thank you.

Mr. Richardson. I want to thank the three of you. Let me ask the two young women a question.

Augusta, you stopped your drug abuse. What made you stop? When you talked about some of the preventive programs, what was it specifically that made you stop? Was it your peers? Was it a specific program or a counselor? And I guess my second question is—and don't be concerned if you disagree with Gardenia on this—but it was mentioned that the program should be family oriented, that it shouldn't just be for youths, that preventive programs should deal more with the elderly, the family, and youths, that perhaps we are targeting too much—I think it was stated in the opening statement you made—just on youth.

Do you think it should be all of you, or do you think that youth needs special attention? Can you remember my two questions?

Augusta, you take the first crack.

Ms. Vea. Well, the reason why I stopped was because in Utah, I used to get good grades and things, and then when I started doing drugs with some of my friends, it seemed like my grades just went low. I didn't care about anything any more, and finally I got caught and I noticed what I was doing wrong.

Mr. Richardson. So it was the fear of punishment that got you to stop?

Ms. Vea. Yes.

Mr. Richardson. Was there any guidance counselor? Was there any program that made you see the light also or was it just the threat of punishment?

Ms. Vea. Well, right now I am on probation, and every time I go to check in with my probation officer, he tells me about—when I first started on probation, he used to talk to me about what alcohol and drugs can do to you, and I just thought that if I want to be a nurse later on, at a future time, I am going to have to stop doing all these things that I am doing wrong.

Mr. **Richardson**. What about your colleague over here? Why don't you give me an answer to those two questions, the first question being: What is the most effective prevention, in your judgment; and second, do you think the program should be more family or more youth?

Ms. **Barber**. Well, I think that recreation facilities and things like that should be year round, not just for these few months, but for the whole year, you know, to keep juveniles' minds off of doing drugs and keep them even more involved with themselves.

And I think that counseling should be in the family, not only for that person, but for the whole family.

Mr. **Richardson**. The whole family?

Ms. **Barber**. Yes.

Mr. **Richardson**. And would you start these programs at home or should those programs be more school oriented, with the family? What happens if a family is out and working? I mean, how can you orient them more toward the family when perhaps your mother and your father or anyone in your family couldn't go to school, to your school? How would you do that?

Ms. **Barber**. Well, like I said earlier in my speech, that should be introduced at the early elementary level so that those kids can go home and tell their parents what they learned at that counseling.

Mr. **Richardson**. Well, Gardenia, do you think in summary that we should start all over and draft a new bill? Do you think we should orient it toward the family and perhaps link up this bill with our entire effort at alcoholism with the Indian population? In other words, you are questioning this approach that it should just be for youth?

Don't feel bad about it. I think you have made some very good points, and I want to make sure we are doing something right, too.

Ms. **King**. Treating alcoholics alone, that is not effective. You have to get the family involved. That is the support, and you cannot expect effective treatment if you are isolating the individual that is sick. You have to have the family involved in it.

I am not asking that this bill be rewritten, but it certainly should be inclusive of the family. If you are looking at prevention, as Augusta mentioned, it is very important to maintain those family and traditional ties.

Mr. **Richardson**. I might add that this bill was just a start as a discussion, but the problem is so serious that we want to have some legislation very soon, but this appears to be a good recommendation, and I look forward to hearing your input a year from now, after we have tried that center in Gallup, that preventive center that will be funded through that private hospital and the Navajo Nation, whether that approach has worked; and maybe, if it has worked, we can incorporate it with some of the juvenile—I am sorry—adolescent programs.

Does the name "juvenile," like "juvenile delinquent," is that your objection?

Ms. **King**. Well, the term "juvenile" itself does connote a lot of negative feelings in that, you know, they have run-ins with the law. That is the understanding that we have gotten.

Mr. **Richardson**. Well, that "juvenile" word was Frank's idea anyway, so we will change that.

Ms. **King**. One last comment, Mr. Chairman. That if there are funds appropriated for the implementation of this bill, that the overhead be considered.

Mr. **Richardson**. So you concur with Mr. Pena's view that the funding should be more directed—that the overhead be reduced and that there be more direct funding to you; is that what you are saying?

Ms. **King**. Yes.

Mr. **Richardson**. All right. Well, I want to thank the three of you, and especially the two young women, who I think conducted themselves very well.

Thank you very much.

I would now like to call as a witness Mr. Bennie Cohoe, executive director of the Ramah Navajo School Board, and I would like Mary Cohoe also to join him at the witness stand, even though she may not have a prepared statement.

Mr. Cohoe, you are a veteran at testifying before committees of Congress, both of you, so you know the ground rules. You know that we would like you to submit your statement for the record and to summarize your statement. I thank you for coming from such a long distance. It is always good to see both of you who are so committed to working with the Congress on behalf of the Indian people.

Mr. Cohoe, welcome to this committee.

[Prepared statement of Bennie Cohoe may be found in appendix II.]

PANEL CONSISTING OF BENNIE COHOE, EXECUTIVE DIRECTOR, RAMAH NAVAJO SCHOOL BOARD, INC., PINE HILL, NM; AND MARY COHOE

Mr. **Cohoe**. Thank you, Mr. Chairman and members of the committee, as well as the legislative staff who are here with us today. My name is Bennie Cohoe. You know me pretty well. I am representing an organization called the Ramah Navajo School Board, Inc.

The Ramah Navajo School Board is a service provider for youths, beginning from 2-year-olds through early childhood programs to the adult members of that community for the last 15 years. And as a service provider administrator, I feel that we do need to really concentrate on putting together legislation that will definitely affect and have a positive impact on the youth of today. And I want to thank the committee for giving me this opportunity to present my views, as well as I wholeheartedly support the legislation.

But some of the concerns I do have I would like to share with you this afternoon, but as a representative of the Ramah Navajo School Board, we are very supportive of the legislation. However, our concerns are that when you get the Federal agencies involved, meaning the Bureau of Indian Affairs and Indian Health Services, they have real strict guidelines which they follow. They are called CFR's.

And if there is certain language in that CFR that does not sit positively as to how they want to do a program, they won't do it if the problem is there. But then again if the CFR does not stipulate it, they won't go over that. And I think they are more frightened now because of the 8102, and they are very rigid. They don't want to do anything other than just to spend the money for whatever the CFR says, and that is going to be a problem.

And one of the other concerns that I have is that I haven't had a chance to work with 638. When 638 came about, what happened was that the Bureau, instead of sending the program dollars down to where they would have impact and have a positive impact with the tribe, they established a whole layer of contract experts, specialists.

So they established a new layer of administration which took up all of the dollars that were supposed to go out in the field. And this is something that we need to be aware of and look out for. So if we are going to do any revision to this legislation, I would like to have this considered.

And the same goes for IHS. IHS has been aware of the Ramah Navajo community's alcoholism problem for numerous years. And I have sent proposals and budget requests to the area office year after year. But then again, the end result has always been the same. We don't have any specific guidelines or programs that we can help you with. Those problems exist right now.

And I would say that in my community right now I have about 75-percent unemployment because of the cutbacks in Federal dollars and the unstable economic situation in my community. I experience every day what alcohol does to the tribal members, beginning from the youth to the adult, and I think that the legislation will help in directing some of these Federal agencies to assist my community because I am very glad to be having something coming about to direct additional resources to my community. So the level of funding would be a problem to me that I think needs to be looked into.

The other one I guess was mentioned here that, you know, there is a need for tribal input. I think the legislation mandates that. You know, you have 1 day, a 5-minute hearing for tribal input, and that's it, and then it then becomes a law, and we are sitting there feeling that we are left out every time. So I think that, you know, that needs to be reemphasized.

Because, you know, having been a service provider for that community for 15 years, I would like to say that my organization should also be considered to test these new programs. We would be willing to work to put together a training program to work with the youth. We are already working with children in that area, and I could really perhaps collaborate with my neighboring tribe, the Zunis, to put a good, comprehensive training program together in that area, as well.

So those are the concerns that I have, and I think that I will be submitting a more detailed written document within the next week or so. I appreciate the time that you have given me today. Perhaps my wife, Mary, has a few other things that she would like to comment on, in addition to what I have stated.

Mr. RICHARDSON. Mrs. Cohoe?

Mrs. COHOE. Thank you, Congressman Richardson, for allowing me to share my viewpoints as well as inviting me up here to share a presentation with such a fine person.

I would like to add to Bennie's statement that the Ramah Navajo School Board and the Ramah Navajo community be recognized in the community's acknowledgement of alcoholism problems. In its acknowledgement, the school board and the community are already in the unique position of providing services. We have contracted with the Indian Health Service for health services. We also recently opened a new group home that serves abused, neglected children, usually as a result of alcoholism problems in the home.

And in agreement with Ms. King, I think I hold prevention and any type of services related to alcoholism in the community should include the family, educational programs and other types of services.

I would also like to speak to this issue as a parent. As a parent, I know that alcoholism will also affect children of all alcoholic parents. Children who share educational programs in the school will be affected. And so if preventive programs can be included in all areas of services that are in the community, I think they will be effective.

We are concerned about the funding level. We will be asking that the funding not take away from already existing quality programs.

Mr. RICHARDSON. Thank you very much. I have no questions. I think your statement is very positive and comprehensive, and I thank you for appearing before this committee.

We will have our next panel, and then we will take a 5-minute break. I sense that either the heat of Albuquerque or the heat of this building is causing many people to wilt and fall asleep. It certainly isn't my speeches. So we will take the next panel, and then we will move into a 5-minute recess.

Mr. RICHARDSON. Mr. Juan Vigil, secretary of Human Services? I don't see him here, so we will move on to Francesca Hernandez, the executive director of the Albuquerque Indian Health Board, accompanied by Mrs. Ona Porter, director of planning and community development.

I would like to welcome both of you to this committee. Your statements will be inserted in the record. I know that when both of you appear, the statements are always comprehensive and full of data and statistics. I want to commend both of you for your professionalism.

See what I mean, statistics, data? Who is going to proceed first?

Ms. HERNANDEZ. She is going to go first.

[Joint prepared statements of Ona Porter and Francesca Hernandez may be found in appendix II.]

PANEL CONSISTING OF ONA PORTER, DIRECTOR, PLANNING AND COMMUNITY DEVELOPMENT, ALBUQUERQUE AREA INDIAN HEALTH BOARD; AND FRANCESCA HERNANDEZ, EXECUTIVE DIRECTOR, ALBUQUERQUE AREA INDIAN HEALTH BOARD

Ms. PORTER. Thank you.

We have essentially three parts, and we will try to be concise as to those three parts.

First of all, we have some specific comments in regard to the bill that we would like to have. We would also like to entertain briefly a discussion of what prevention is. And finally, we would like to respond to a question you asked earlier: What do we need to do to create programs that are different than the ones that are already in place?

First, specifically in regard to the provisions of H.R. 1156, we grouped the provisions into categories that we hope will permit some concise comment.

Our first group is resource sharing and coordination. This is a critical consideration that should be strictly adhered to not only among the BIA and IHS, but with their contractors, tribal schools, and State programs. It must be understood, however, that it is not merely issues of territoriality which impede cooperation now, but rather the rigid funding agency policies and regulations. And those would have to be addressed if, in fact, we are to achieve the cooperation that is intended.

The next category is Indian education and counseling. Provisions which permit drug and alcohol counseling should, instead, require it. At the very minimum, Indian Education Program staff should be trained in the early identification of alcohol and drug problems and should have appropriate referral resources for intervention and treatment.

The next is schools as recreation and counseling centers. We believe also that the schools should be open all year round, not just in the summer, and they should be open for before school programs and after school programs.

The next group is detention after arrest and temporary emergency shelters. While the idea of other-than-jail detention is excellent, the possibility for implementation undercurrent conditions is slim to none. A mental health needs assessment of children which we currently are conducting in a five-State area of the Southwest, indicates that there is an absolute crisis in out-of-home placement resources in Indian communities.

Often there is no shelter even for those in need of protective custody due to severe abuse and neglect. Rarely are children in need of temporary shelter over the age of 6 ever placed because of the availability constraints.

Also, any attempts to relieve this crisis through payment to private individuals should also include budget items to provide training for foster families and some means to monitor these families.

Training needs assessment; included in the assessment should be not only the number of children in need of services, but the kind of treatment required, the appropriate setting for same and the duration of various treatment structured aftercare and the implied and companion treatment needs of the families of dependent children.

Next is comprehensive alcohol and drug abuse treatment. Treatment programs should be designed to meet the specific needs of adolescents. They should not be an adaptation or an extension of adult services. There must be a continuum of care available which includes but is not limited to early identification, structured intervention, outpatient, limited inpatient, which would be 45 days, extended inpatient, which would be 24 to 36 months, aftercare, codependency as a primary diagnosis and intensive family therapy.

The training mandated in the bill for CHR's, school, clinic, law enforcement, and shelter personnel is essential. There must be some provision made, however, to describe which people should receive training for what aspects of alcohol and drug abuse.

For instance, all people directly involved with students should be skilled in the identification of drug and alcohol problems and referral procedures. Also, someone in each of those settings should be skilled in crisis intervention, structured interventions, alcohol and drug assessments, treatment planning and treatment network development. Someone else should be skilled in developing effective, comprehensive prevention programs.

Further, parent education classes for all people who have students enrolled in federally funded day care and Head Start Programs should be required for a minimum of 40 hours a year. These classes should be aimed at developing parenting skills and not specifically for drug education.

The average cost in this Nation to treat a chemically dependent young person is between $12,000 and $20,000 for a limited inpatient program, and the success rate for even the best programs is around 30 percent. Therefore, we believe it behooves the Congress to consider the addition to the bill of some very strong prevention components.

While we understand that it says "prevention," we believe that primarily the focus of the bill is treatment for young people.

Ms. **HERNANDEZ**. I wish to clarify again what I am going to say, that this is not really a prevention bill. It is a search for more effective treatment for adolescents, and that is commendable. I think it is very important that we do that. We need good treatment, and with early identification and intervention, that will happen.

We don't have any facilities for these young people. We don't have it anywhere in this country for any group. We have no good treatment for adolescents because their needs are very different.

It is important, when we talk about prevention, that we look at and address the root process of the problem. That is what prevention means. It means that we stop it from starting. When we are taking the kids already when they are on drugs, we are not preventing it. What we are doing is intervening to keep the disease from going on. We are not actually preventing it.

One of the things that I wanted to say is that all the problems that deal with young people today are interconnected. Alcoholism is only one symptom of many. School performance, very poor school performance, criminal activity, suicide, teenage pregnancy, and many other problems are all interconnected, and they have one basic root in common. That is that kids are growing up without the skills to be capable people. That is really what the issue is.

They don't know how to deal with the world in which they live, and those are things that we really need to address, whether they are in the home, whether they are in the schools, or in the communities in general.

Every activity in the community must have the prevention of alcoholism as a top priority in that community. What we are encouraging is that whatever it is, economic development or whatever it is, you have got to think about what the componency in your community is and make it a top priority to deal with that in whatever plans you make.

In the schools we strongly believe that it has to be incorporated into the curriculum, the development of the skills that make kids capable to function well in the world they are living in. What I am saying is that doesn't mean that they have to turn off from the traditional system. What they need is the traditional system and the excellent skills, if they have them, but the confusion that they have between the traditional system and the modern society is part of the problem that they are facing.

They don't have a place to be. They don't have a sense of identity. They don't have a sense of meaning in their lives, and that has to be restored. That has to be restored by developing the skills, and who can develop those? The people who are raising, socializing, and interacting with the children. And those are parents and teachers and those adults who are significant in their lives.

One of the things that I want to say—there have been a couple of people who have talked about family therapy. I think that is a very important issue to address.

Part of the problem in our families is that not only the person addicted is sick, that person addicted to the drugs or whatever it is, but the rest of the family is addicted to the behavior of that person. That is what we call codependency. We need to treat people not only for the dependency on alcoholism, but for the disruption that alcoholism has created in their families and how they relate to one another. So, therefore, we need to treat the families for codependency, and we need to treat the addicted person with that system.

And in our case, because our communities are impacted directly or indirectly 100 percent by alcoholism or codependency, the whole community has to be dealt with as far as we are talking about developing community health systems. That is essentially the issue that we brought up in Gallup at the least hearing.

In terms of prevention then, to summarize this part, education of the families is one of the things that we would be striving for. Skills to function well in today's world, with the focus on teachers and adults and their different means of doing it.

Besides education, besides teacher training in how to incorporate the basic skills that people need, they should have viable role models, intrapersonal skills, interpersonal skills, viewing themselves as problem solvers, having faith in their personal resources to deal with whatever they face. These are essential skills, and those can be incorporated in whatever class they have, science, or math, or whatever activity they are having. They, of course, should make sure that the teachers themselves are developed enough and have prepared themselves enough before expecting them to develop young people.

But there are other means. Advocacy programs can be established without really having to have much more expense than there is already. It is a matter of redirecting resources rather than investing more.

Encouraging tighter social integration, social development. Many people think of problems developing only in economic terms. Problems alone are not going to develop people socially. There has to be some kind of effort to develop people besides economically; socially, as well.

And so it is with the leadership, because the leaders are often not knowledgeable of how to go about solving problems.

And there are things that have to be done outside of the community, and we have to address other issues, such as advertising, the liquor industry sponsorship of events in the community, because all of that is a role model for the young people, and there are other things that our statement clarifies for you.

Another thing I wanted to mention is the early identification and prevention, that that is very important because there is a tremendous need for treatment, and this is not only for our young people, but for everyone. But in our statement, we talk about employee assistance programs, teacher training, student assistance programs, and all kinds of other possibilities to deal with it.

Ms. **Porter**. For just a moment I would like to refer you to the charts that we gave you.

The first one, "Interrelationships With the Problem" looks like this. Essentially what we are trying to picture there is that all of those problems have a personal dimension, a family dimension, a social dimension, and an economic dimension, and a political dimension. And if, in fact, we do not address this problem in all of those realms, we won't touch it.

The next thing that we believe it is important to understand is the difference between prevention, early identification and intervention and treatment, and for that purpose, we have pronged the targets of a three-pronged attack for you.

And we want to show you that essentially in primary prevention what we are targeting is children, parents, and families, all those groups and the agencies that touch them, and also the idea that this is wellness oriented. So we are working toward something, rather than against something here.

In early identification, we have some very logical places to address the needs of people, legal offenders, patients, drivers, students, and workers. In all of those places there is an opportunity for us to find people in the early stages of alcohol and drug abuse.

And in treatment we need to understand that essentially right now what we are doing is just working with these alcohol problems and alcoholics and that all our treatment centers are designed to do that. If we are, in fact, going to adopt a middle prong in early identification, then we do need a different treatment orientation for those individuals. One of the things is that today the treatment centers have actually become shelters for most people. They are not really getting people well at all.

The other thing to understand is what are the limitations and what are the possibilities of each of the three areas? In primary intervention, again the orientation is wellness. It is long range and it includes the whole community. It means relieving the stress and the powerlessness within communities that is giving rise to the problem of alcoholism. And on the other hand, early identification and intervention, the orientation is that it is private, it is immediate and it is individual. We are solving problems one at a time, and we can't hope for either one of those to be prevention.

The second-to-last issue is that we want to have you understand that all efforts must be merged and be directly related to tribal priorities and tribal needs. And the model that we show you there is a model in community development where the tribal needs and priorities are at the center, a task force and the community work together around those needs and issues to make plants to take action and develop programs for a controlled change and a strong and secure tomorrow.

Finally, we believe that it is important to understand that we have to have all of those three parts, so we have designed that on a wheel that shows you that if you take out any of those parts, the whole system falls and your hopes for the future are failures.

This task must be interconnected and multifaceted. It has to have different approaches to meet the different needs of different parts of the population. And it works together with all systems and all people to bring health, strength, and productivity to the community.

I want to mention a couple of things. One of them is that a study in Orange County, CA, showed that two-thirds of the 2,500 polled, ages 7 to 21, were already serious drinkers. I think that is very scary.

In our communities, in a study that we are doing right now, 80 percent of them are already involved in drinking by the time they are 10 or 12 years old.

Mr. RICHARDSON. Let me commend you for your statement. As usual, it is very comprehensive. One of the most compelling statistics that I have seen in your statement is that the average cost in this Nation to treat a chemically dependent young person is between $12,000 and $20,000. This is just for a limited inpatient program, and the success rate of available treatment hovers at around the 30-percent mark. Therefore, 70 percent of those that are treated at an approximate cost of, say, $20,000, have not been successful, and I think that is a dramatic statistic that really summarizes the problem.

Ms. HERNANDEZ. I think it is an incredible situation, and we have many children that we have identified, but we don't know what to do with them because we don't have the money, the contractors don't have the money, the treatment programs are not good for them, and if we want to send somebody to the care unit, it costs us $15,000, and we don't know that they will even get well.

Mr. RICHARDSON. We will communicate your views to the Office of Management and Budget, which seems to estimate the effectiveness of the programs by the number of dollars they reduced it in the previous years. They don't look at the long-term investment that we should be making for an effective preventive program.

You have shown me a number of statistics and charts, and obviously there is a tremendous amount of expertise in your organization.

Let me ask you what I asked Gilbert Pena and what I asked Ms. King about the bureaucratization of the health care programs. And I notice that you don't have a chart for that, so I am going to ask you that.

How would you channel some of these programs? Give me a bureaucratic structure that will work.

Ms. **Hernandez**. I will take a shot at it.

First of all, I am going to take a position that is very unpopular. One of those is that we do need to look at the entire health system of the Indian Health Service and reconsider how we are administering health to the people.

Specifically, in terms of alcoholism, I think the moneys that are available aren't always enough to do what we are talking about what we need to do, but even the ones that are there need to be redirected in a whole different way. The way that it is being done right now is not an effective way, period, and many people don't even want to touch that because they don't want to lose the employment that comes from that or for whatever other reasons.

Ms. **Porter**. In terms of bureaucracy, I guess one of our biggest objections is that there will be salaries there that could be put into direct services.

In our prevention program—we have a prevention program that has been operating for about 15 months—it is funded out of mental health funds. It is not out of alcoholism funds because there are no moneys there. We have an excellent relationship with Indian Health Service. They are very, very supportive of our program, but the thing is, how much is there tied up within the Indian Health Service that might be better applied to the communities?

We believe that people need to be accountable, and they need to be accountable to their people, and they need to be accountable to their funding sources. So there needs to be some level of monitoring, there needs to be some level of standardization, and I think we would be foolish to propose something different than that.

But we also need to look at that in a very realistic sense and say, "How much of that do we need for the programs that we have in place, and what should their role be?" We believe that their role should be a very clear leadership, that it should be careful monitoring to keep people on the track and that accountability should be a big factor.

Mr. **Richardson**. Let me conclude by asking you what may be a no-no when we discuss some of these issues, something that people don't want to talk about, but perhaps we should. And that is the issue of contracting out. In other words, how much are we really hindering ourselves by not being more objective and letting private facilities get involved in some of these alcoholism programs?

Is the whole tribal control issue the key? Do we lose the effectiveness of the program, statutorily? Is it impossible? Why not do some of the things like we are trying to do in Navajo, with a priate facility involved in the alcoholism program, and perhaps get experts? I am sure there have been some successful adolescent alcoholism programs that maybe we just don't know about. What about contracting out to private sources?

Ms. **Hernandez**. OK, let me say one thing about that. First of all, I don't think it would be a good thing to just pass a rule and say, "We are going to do it all by contracting," or "We are going to do it all by whatever." I think different situations will require different approaches. I think that contracting out should be something considered very seriously where there are no other alternatives and that the well-being of that individual, that family, that community is the only thing that should be taken into consideration when we are making a decision on whether the treatment that is available through the Indian Health Service, either in the communities or outside of those communities, is applicable or not, is the right thing to do, and in some cases, it has to be contracted out.

Now, one of the things that we have talked about for a long period of time is that the money should be utilized for the ones that are already in place plus extra money to create a very good, top-quality treatment center for Indian people that is regional and that addresses family therapy, adolescent treatment and other people this way.

Now, that doesn't mean that that system, by itself, will operate alone. I think that there should be other systems, other programs, as well, private programs as well.

Ms. **Porter**. I think right now, with children and adolescents, we don't really have any options. There is a new program operating in New Mexico that has only begun to work with adolescents. In dealing with the adult population, they have had in the last year and a half 28 or 30 Indian people go through their program; 28 of them are still sober. We have lots of hope for what they are going to do with the adolescent program.

And right now that seems to be one of the most viable resources in New Mexico, and we really feel that it should be—well, it is extremely unfortunate that Indian people can't take advantage of that program, and to a large degree they cannot. The people who have gone there were Indian people. There have been a few people placed there on contract health services money, but the majority have gone there through third-party payments of insurance, either their tribal insurance or their company insurance, and that program that I am talking about is not one of the most expensive. It is $9,000 a year.

Mr. **Richardson**. Let me just make this point one last time, and then we will go into our recess for 5 minutes and then we will proceed with Joe Abeyta, of the Santa Fe Indian School.

But you are familiar with the drug treatment center in Espanola and the methods that they use there, Delancey Street. Now that is a private organization, and they have unique methods and they have an alarmingly high success rate, to my knowledge, probably because they have very little Government intervention. They do it themselves.

But apart from that, why can't we combine the best of that, which is an existing program, with perhaps some kind of application to our Indian people? Why, for instance—I had an amendment passed in the Indian health bill, because if you are an Indian veteran in Gallup, NM, and you also can get health care from the IHS, you can't get your veteran's treatment at the IHS Hospital. You have to go all the way down to Albuquerque. You know how people don't want to change. Now this amendment, for the first time, allows an interchange between the IHS and the VA, but to get that passed, you would think that I was trying to uproot Mount Rushmore. Now, that's bureaucracy.

Now, Ms. Hernandez, you mentioned, if all else fails, then go to a private program. What if there is that Delancy Street? What if there is a rural Hispanic program in Taos, or what if there is a successful South Valley program and there are some very good people like yourself that might be prohibited by law from not running the program, but just participating in it? Try to be bold. What——

Ms. **Hernandez**. No; I think that that would be an acceptable way of looking at it. I agree with that. I think that that would be very good.

One of the things that I believe is that very often it is the people who creatively engineer something different that are going to be most effective. However, that doesn't serve all the people all the time. That is what I was trying to say, that no one program will serve the needs of every single individual and that we should be open to have Indian people be treated, whatever their needs, that they be treated, whether it is at a rural program somewhere or whether it is a good program in their community.

Because our experience is that all of them really are not treated effectively in the same position, but that is how it is, between you and I.

Mr. **Richardson**. I am glad to hear you say that. We will now adjourn for 5 minutes and resume testimony with Mr. Joe Abeyta.

AFTER RECESS

Mr. **Richardson**. The committee will come to order.

We will now proceed with my good friend, Joe Abeyta, superintendent of the Santa Fe Indian School. I want to welcome you, Joe. It is always good to see you, Joe. I am sorry for the delay. I have seen you waiting patiently. Please proceed.

You know that your statement will be presented in the record. Would you introduce your colleague to the committee?

[Prepared statement of Joseph Abeyta may be found in appendix II.]

PANEL CONSISTING OF JOSEPH ABEYTA, SUPERINTENDENT, SANTA FE INDIAN SCHOOL; AND JOSEPH QUINTANA, COORDINATOR FOR SUBSTANCE ABUSE PROGRAM, SANTA FE INDIAN SCHOOL

Mr. **Abeyta**. I would like to present Joseph Quintana, who is the coordinator for the substance abuse program that we have on our Santa Fe Indian School campus.

Mr. Richardson, before we get started, I would like to take the opportunity to thank you on behalf of all of my students and on behalf of all of the staff, all of the people associated with the Indian school, for the support that you have given us over the years.

You know as well as I do that the All Indian Pueblo Council has taken on, as part of a 638 contract, in attempting to manage or administer an education program, has had its difficulties. But because of your support, we have realized some success, we have realized some progress that hopefully will continue.

As you are well aware, we are located in Santa Fe, NM, out of Cerrillos Road——

Mr. **Richardson**. Thank you for the nice words. I just wanted to make sure that you all heard them.

Mr. **Abeyta**. He is a good man.

We have an enrollment of about 450 youngsters. Our youngsters are in grades 7 through 12. They come primarily from the pueblo communities. We do have a few Navajo students there and we do have a few Apache students.

Our position, very simply, Mr. Richardson, is that we support H.R. 1156. We feel that it outlines quite adequately parameters attempting to address a very, very serious problem that is confronting not only Indian youth, but young people throughout the country.

A number of years ago, when we started our program, I think that there was a feeling that we didn't have a problem. I don't know whether it was a false sense of pride or exactly what it was. I am not sure, but over the years we have come to a very, very clear, acute awareness that there is a very, very serious problem.

It is one that has not been addressed with any type of consistency, with any type of coordination, with any type of intensity, and I hope that this piece of legislation that has been introduced is going to make its way through the Congress and that Indian youngsters throughout the country are going to benefit from some good ideas.

I mentioned that the legislation seems to outline quite well some parameters. I think that it is the responsibility of the local communities to work with the implementers of the legislation in working out the details that will assure that there is some awareness in regard to the problem that exists, an awareness through all communities. Parents need to understand, staff needs to understand that substance abuse is a very, very serious problem and it needs to be placed at the top of the list in terms of priority and needs to have the attention and support of everyone concerned.

I think also that any program needs to stress individual responsibility. By individual responsibility, I mean that youngsters in school programs, youngsters involved in substance abuse, need to accept some responsibility for resolving the problem. I don't mean to sound controversial or start an argument, but I think that in some cases we have gone out of our way to provide programs and services in a way that has compromised to an extent the responsibility that youngsters have got to have for the resolving of their own problems and difficulties.

And I hope that if this legislation passes and money is made available, that the programs that do result accept the fact that we have got sharp youngsters that are intelligent, that are aggressive, that are aware, and that they need to be involved in the development and implementation of the programs.

I think that the programs need to have available also alternatives to substance abuse. Those alternatives are many, but I think that they need to come as a result of participation on the part of youngsters.

The final thing that I think is of critical importance in regard to a potential substance abuse program is a component that has to do with research, Mr. Richardson. There are a lot of people like Mr. Quintana that are involved on a daily basis with prevention programs and counseling programs and are gaining very, very valuable information day in and day out as they work with kids.

I would like very much to see the possibility or see the implementation of a research component that would allow these people, as an example, at the beginning of the year to state some hypotheses about what works for that particular group that they have in their charge, and as a component during the course of the year of the implementation of a project, evaluate and test the success or the failure of a program and use that data as a means to strengthen a program that targets a specific group of people.

I think that in the past we have had a tendency to address some of our very unique problems on our reservations and in our schools and in our communities by referencing what is done in New York, referencing what is done in California. Not to say that those are good programs or that they aren't a good reference, but sometimes we buy them lock, stock, and barrel and assume that because it has worked for another population, the program has potential for working with our kids.

I think that we are sophisticated to the point that we want to have a role in evaluating strategies that work for us. We want an opportunity to consider unique approaches that take into account all the differences that exist with regard to the backgrounds and environments that our people come from, pull all of that together, and initiate some programs that have high potential for success.

Mr. Richardson, we have submitted for the record an extensive statement that is available. It breaks down the legislation item by item and makes comments.

In conclusion, I would simply like to say that we support the legislation. We believe that it is based on a parameter that has tremendous potential for impacting a very serious problem.

I am going to, with your permission, ask Joe to touch very, very briefly on the substance abuse program that we have got in existence on the Santa Fe Indian School campus. It is a project that has been recognized by the New Mexico State Legislature and by the Governor of the State as being an exemplary program. And without stealing anything from Joe, I would simply like to say that in my opinion the reason that it is working is because we have got people like Joe that are, in fact, commited to kids that are, in fact, dedicated to resolving a problem.

And in the final analysis, not only substance abuse programs, but reading programs have a high potential for success if the programs are fortunate to have people that believe in kids, that are committed to success. People make the difference, and I hope that H.R. 1156 is funded and that there are financial resources available for people that are trying so very, very hard to address a very, very critical problem.

Mr. RICHARDSON. Thank you, Joe.

Mr. Quintana, please proceed. You have gotten quite an advance billing, so we are expecting a superior statement.

Mr. **Quintana**. Well, it is an honor to be here, Congressman Richardson, Mr. Chairman, committee members.

I feel that at the Santa Fe Indian School we have tried to do what we can to help our students there in regard to the substance abuse problems that are around the school, and not only in the school, but in the community. I feel that it is something that is good from this bill, H.R.1156, that you have gone for the legislation as far as, I think, putting more emphasis on the problems with our Indian youth, I feel that the Santa Fe Indian School we have tried to do what we can through counseling, which includes individual, group, family.

And it seems to me that through this prevention program we have some things in the bill that pertain to family participation, which I think is very necessary in order to work with the youth of our Native American people. And I feel that with this legislation, it is something that puts a lot of emphasis on the problems that we have with our Native American Indians.

I feel fortunate to be asked here by our superintendent to just have a little say-so in some of the things that have been coming up with the school. I think one of the main things, too, that a lot of people have brought out is that, you know, there are programs that are geared more toward adults, which is true. I think that again you have to put more emphasis on the youths themselves.

I liked the statement that was made as far as trying to help the Indian youths even from kindergarten on up. A lot of times at the Santa Fe Indian School we have students that have already established a pattern, even in junior high, and so we have to deal with treatment in regard to some of these students. But I feel this bill will put a lot of emphasis on some of the problems and help us deal with Indian youth.

Mr. **Richardson**. Mr. Quintana, let me ask you, as somebody out in the field, you mentioned the importance of family participation. The programs that you administer, how do they involve the family? Be specific in terms of, indicate one program that you think is most successful.

Mr. **Quintana**. Well, the students that get involved, say, in violations regarding substance abuse at the school, we make it mandatory for the student to have the parents there for a family counseling session. And in this regard, we try to get the family involved with, say, the treatments or prevention, whatever the situation calls for at the time, to get the family involved with the student.

A lot of times they have negative attitude or, "Gosh, it is so hard to come." But there are underlying problems probably in the family that the family does not want to get out. But I strongly go with the fact that we should get family participation.

Mr. **Richardson**. Are you familiar with the San Juan Program, the program that has this system in the San Juan Pueblo that Carl Lujan administers that has that work program, in addition to the counseling?

Mr. **Quintana**. Yes, I am.

Mr. **Richardson**. What do you think of that approach?

Mr. **Quintana**. Well, I think that approach is very good. When the students, like on campus at the school, do get written up, there are also what I call alternatives that we try to give them, including a work program.

Mr. **Richardson**. Now you have come out obviously very diplomatically in favor—you came out in favor of the bill, Mr. Quintana, but you also mentioned the importance of family participation. Ms. King, a previous witness, said that she thought the bill was deficient because we didn't have enough family participation.

Now is it possible to draft a bill that is oriented toward Indian juveniles and have a viable family component? And if there is a family component, how would you do it, given the potential logistical problems? Are we talking about counseling sessions in the school that are mandatory for all the kids that are preventive that may be directed at all children, even if they haven't had a drug or a substance abuse problem? Give me an idea of what might be effective.

Mr. **Quintana**. Well, what we are looking at, and we are going into planning stages, but this has happened on several occasions, is that we have mandatory alcohol and drug education at the school.

Mr. **Richardson**. For parents also?

Mr. **Quintana**. Right.

Mr. **Richardson**. You do?

Mr. **Quintana**. Well, we are looking at that. But we do have some, like I said, where the parents do come in.

Mr. **Richardson**. Well, that seems to be a very good thing to do. Mr. Abeyta.

Mr. **Abeyta**. Mr. Richardson, I was just going to comment that our programs are probably divided up into two parts in Santa Fe.

The first part of the program accepts that there is a group of youngsters in the school that are experimenting, and consequently need a specific kind of solution and program.

There is another group of students that Joe works with and that he has identified as having a more serious problem. We have built our program using some of our own money. We made a decision internally that the problem needs attention. And we are taking our regular program dollars and have allocated them to a special project for classes that are mandatory, as Joe discussed, that are part of what we call our medium program. That program does have, as a mandatory part of it, the involvement and the participation of parents.

Now on occasion there are some parents that are a little hesitant about coming to school. But I think that more and more people are realizing that our approach is one of service, one intended to help and resolve problems, not one intended to disparage anyone or punish or hurt anyone. And I think that on occasion, if you are not careful, sometimes substance abuse programs wind up being programs that have an approach that hamper or sometimes turn kids away, rather than bring them into a circle where help is available and where attention can be focused.

Mr. **Richardson**. Joe, I won't ask you the question about the bureaucracy because I know the answer, given your problems with 638. And you know that we initiated a GAO investigation, and I believe the results were concluded a few days ago, and we know your concern there and the problems you have had with redtape.

And hopefully what you would like to do is, I know you are not on the witness list, but I would like you to take a copy of the BIA Accountability Act, too, and see if there are ways that you can give us some input on that. I don't think you are a scheduled witness, but you should be because of your frustrations with the BIA.

Let me say, Mr. Quintana, if you have any additional ideas, I would like you to submit them to the committee or any kind of statement for the record.

And let me just close by thanking both of you and commending Mr. Quintana. Obviously you have come very well recommended, and it is possible that, as we draft this bill, you can help us deal with some of these fundamental issues that have been raised.

One, do we make it more a family orientation than strictly youth? Two, the bureaucracy of the program, how do we most effectively deliver these services? Three, how do we collect all this data? How do we bring forth the treatment programs that have worked, and who decides which ones have worked. And what is this data collection and methodology, all these fancy words, what do they mean, practically?

And lastly, are we, in effect, looking at the most effective way to channel these programs? Do we use more private contracting, which I guess is part of the bureaucratic question.

Those are the kinds of things that I would like to hear from you as somebody that is right out in the field or the firing line. I know how concerned Joe is, but you are out on the firing line. You see the people and the humiliation and you see the suffering and you see the problems. And anybody that is a counselor and is out there in the frontline, I salute you and I wish you the best. And the committee, as I said, will be open for the record for 2 weeks following his hearing, so your statement would be part of the congressional presentation that is made to the Committee on Interior.

Thank you both, Mr. Quintana and Joe. It is always good to see you.

Our next witness is Dr. Joanna Clevenger, Council of Navajo Physicians.

Dr. Clevenger, welcome to this committee. Are you accompanied by anyone from your staff?

Dr. CLEVENGER. No.

Mr. RICHARDSON. You will be making your presentation yourself.

[Prepared statement of Joanna Clevenger may be found in appendix II.]

STATEMENT OF JOANNA CLEVENGER, M.D., COUNCIL OF NAVAJO PHYSICIANS

Ms. CLEVENGER. First of all, thank you, Mr. Richardson and the members of the committee, for the invitation to speak. I am a psychiatrist in private practice in Dallas, TX, so my normal, day-today work is not with Indian people. But I happen to have two areas that I do think I have something to offer.

First of all, my entire practice is dealing with adolescents and particularly adolescents who have serious psychiatric problems and who are hospitalized at a private hospital in Dallas, and I work with these kids anywhere from 3 months to 3 years in arresting multiple problems, but often including drug and alcohol abuse.

Also, I am a Navajo physician, and my medical school training was paid for by the Navajo Tribe. And I am very appreciative of being here, able to say that I am a Navajo physician.

Third, I think that, as with many people that have already spoken, alcoholism is very much a day-to-day part of my life and my family. Alcoholism is a medical disease. I think it is a genetic disease. I think unfortunately Indian people have sort of gotten a bad loading as far as genetic vulnerability to alcoholism and drug abuse.

I have a 21-year-old daughter who is 10 months into a recovery program after approximately 5 years of very, very difficult alcoholism.

Also, I want to commend the previous people who testified, particularly Mr. Abeyta. I think he said everything that I want to say from his vantage point. I will merely say it again from a medical or psychiatric standpoint. I think what he is saying is very, very sound, and I think also Ms. King and what she had to say.

I am a charter member of the Council of Navajo Physicians, which is a new and very young organization of all of us who are both Navajo and physicians, and we are urging that the bill include medical participation and particularly psychiatric participation. Your words earlier about not having to redo things that have already been done, I think many alcoholism programs neglect the medical input and, therefore, have to struggle along and make some mistakes that need not be made.

Also, I really am sort of offended by the education by posters idea. I think it takes personal input and personal relationships to make an impact. That impact has to be people with the dedication of some of the people that have spoken to you today.

I also feel that alcoholism is only a part of the picture. I think other people who testified also have said that. I am also alarmed that, with alcoholism programs, alcoholism seems to be, if that is diagnosed and you take care of that, then everything else goes away, and that simply is not true.

I see in my day-to-day practice kids that would not be able to make any changes in their lives if their other illnesses, other difficulties, were not also addressed, such as depression, such as thinking disorders, such as learning disabilities. So a tunnelvision on this I think can really be fatal for the outcome of any program.

I also would like to underline what Mr. Abeyta has testified, that certain clinical care and research can be synergistic. Research about what I do day to day helps me be a better physician tomorrow and next year and from this point onward. If I do not pause to take a look at what I am doing and why it works, I may somehow be convinced that I am that important in what happens, where it may be factors that are not within me, but within a broader system.

In the past, I want to mention one research project that have a very, very fine life, which was a model dormitory project that was carried out by Dr. Robert Bergman, who was then with the Indian Health Service Mental Health Program. This was a project that began in 1969. And I think that perhaps some of the preventive issues in the bill that you are proposing, that experience is there. It is detailed, the costs are detailed, the outcomes are detailed. And undoubtedly the kids that were a part of that project could be followed today and the impacts of such a project and its benefits could be documented today.

This was addressing 200 kids in a small boarding school from the age of 6 to 10. They would now be 15 or 16 years older. It would be interesting to understand what from that dormitory project was effective in their eventual doing well.

I believe that is all I have to say. Thank you very much.

Mr. **Richardson**. Thank you, Doctor. I would like to commend you for your statement.

There are two things you said I would like your views on. The first was, you mentioned the number of Indian people involved in some of these projects. Now I was reading in the documents the staff prepared that the only survey that has been made of Indian youth alcoholism was compiled by a total of 936 people. I am talking about professors, counselors, law enforcement people, et cetera. Only 84 of those 900 and some people were Indians. Now why is that?

Could it be that the approach that we are taking is that there is not enough of peer, Indian-to-Indian relationship in the treatment, and I don't mean to say that we cannot have a combination of both, but that seems like a big disparity of those 900 involved, under 100, which would be less than 10 percent, 6 percent, are Indian. Is this a factor that perhaps we need to address, in your judgment?

Ms. **Clevenger**. Very much so. I guess my experience along this line would be a little bit different. For example, when the American Psychiatric Association was getting together a group of people to address the psychiatric needs of Indian people, they said they couldn't find any Indian psychiatrists, and that is a favorite sort of bureaucratic hole or position kind of deal, we cannot find qualified Indian people who can do whatever, teach, weave, run programs, be accountable or be alcoholism researchers.

We do have an American Indian psychiatry and mental research project on alcoholism up at the VA system in Seattle with Dale Walker. He would be a resource person, I would think, who would know a lot about——

Mr. **Richardson**. But how many Dr. Walkers, I wonder, are there in New Mexico?

Ms. **Clevenger**. Well, there are 16 Navajo physicians, and I am the only psychiatrist among those.

Mr. **Richardson**. I meant psychiatrists.

Ms. **Clevenger**. I am the only psychiatrist that is Navajo, but there is a wide population——

Mr. **Richardson**. There are 16 Navajo physicians?

Ms. **Clevenger**. Yes.

Mr. **Richardson**. That is it?

Ms. **Clevenger**. We are very proud of having the 16.

Mr. **Richardson**. Well, I commend you, but that is not enough. There are 132,000 Navajos.

Ms. **Clevenger**. Yes.

Mr. RICHARDSON. How many Pueblo physicians are there? I don't mean to put you on the firing line, but anybody in the audience from the New Mexico Pueblos, how many—where is Gilbert Pena? He knows everything.

Do you know, Gilbert?

Mr. PENA. Just myself and Alvino. I don't know. I know we have some in Taos. I would venture to say a handful, about 10, probably, at the most.

Mr. RICHARDSON. Are we doing anything with the University of New Mexico Medical School to improve that?

Ms. CLEVENGER. Well, I am also a member of the American Association of Indian Physicians. Yes, the medical school here has been very helpful in educating Indian people, Navajo and Pueblo, into medicine. What I am saying is that those who are available are overlooked for their talent and are not given an opportunity to perhaps have the kind of input that they could have.

Mr. RICHARDSON. The second question I wanted to ask you, you mentioned everybody here talks about education, we need more education. And you seem to downgrade the poster in favor of the more person-to-person, interpersonal approach, and my question is this. How influential and how susceptible are Indian children to the mass media?

I have had beer companies come to me and say, "We want to do something about the spread of alcoholism and drunk driving." Of course, they are worried that there is going to be legislation banning advertising, so they have something ulterior, also.

How effective is it, for instance, for a beer company on a reservation or in an urban Indian area to be involved in making those posters and those TV ads? How susceptible are Indian children to television and the mass media, in the absence of any kind of—they don't have a job. Many of the Indian youth population economically is in very sad shape. They have a very high unemployment rate.

Are we being a bit downgrading of the media, when perhaps we should utilize positively those posters, those TV ads? I am just being the devil's advocate. I don't know the answer to that.

Ms. CLEVENGER. Well, I am afraid I don't know the answer, either. I can only give you my personal opinion that I don't think Indians are any more susceptible to that kind of advertising than other populations within this country.

What I think Dr. Bergman's project so beautifully demonstrated was that with more teachers' aides, with more house parents in dormitories, with more community input into skills such as weaving and traditional arts and crafts sorts of things, that kind of personal input, with good supervision and training, made a difference on those kids.

Whether the advertising makes a difference or not, I am sure it is a factor, but the personal makes the most impact.

Mr. RICHARDSON. Now psychiatry, how much is psychiatry a component of any IHS alcoholism program? Are you saying that it is not?

Ms. CLEVENGER. I think they are very divided.

Mr. RICHARDSON. Very divided?

Ms. CLEVENGER. There is the alcoholism program and then there are the Indian mental health programs. I think the two women from the Albuquerque Indian Board talked about that. And I would like to see them under the Indian Health Service Mental Health Program. I would also like to see input from medical school departments of psychiatry into some of this.

This can be a very rich training area for psychiatric residents. They have a lot of energy and a lot of creativity.

Mr. RICHARDSON. I hope that in the next year that this committee or myself especially would appreciate your input on the success rate of our demonstration project in Gallup, the one that we are creating with the Friendship Hospital, which I know emphasizes psychiatry because I wrote the thing myself. Well, with all deference to Frank. The staff does everything. We just sort of get up here and read what they tell us to read. But I do hope that in the year you will give us your views on that.

Ms. CLEVENGER. I will make it a point to be there and to visit them.

Thank you.

Mr. RICHARDSON. Thank you very much, Dr. Clevenger.

The president of the Jicarilla Apaches, Mr. Leonard Atole; Mr. Wendell Chino, president of the Mescalero Apache Tribe. I know Wendell is not here, because if Wendell were here, we would know. So I guess they have not made it yet.

John Baker, from the Souther Ute Tribe? Mr. Baker, please proceed. Mr. Baker, welcome to this committee. Your statement will be incorporated in the record.

Would you identify your colleague with you?

[Prepared statement of John B. Baker, Jr., may be found in appendix II.]

STATEMENT OF JOHN B. BAKER, JR., REPRESENTING THE SOUTHERN UTE INDIAN TRIBAL COUNCIL, IGNACIO, CO, ACCOMPANIED BY VIOLET PEABODY, COUNCIL MEMBER

Mr. BAKER. Mr. Chairman, members of the committee, my name is John B. Baker, Jr. My colleague is council member Violet Peabody. We are from Ignacio, CO.

The Southern Ute Indian Tribal Council fully supports the objectives of the proposed Indian Juvenile Alcohol and Drug Abuse Prevention Act, H.R. 1156. In its present form, the proposed legislation represents a positive, constructive approach toward solving a longstanding problem that has become almost pervasive among many tribal groups of Native Americans.

Accordingly, our tribal council is prepared to make available personnel and physical resources of the Southern Ute Indian Tribe, in collaboration with the Federal Government and its designated agencies and organizations, to help establish a comprehensive program that will bring under lasting control the deleterious abuses of alcohol and illicit drugs among our own and other Indian tribes.

The Southern Ute Indian Tribal Council recommends the following: No. 1, that the provisions of sections 204(a) and 204(b) of the proposed act which pertain to Bureau of Indian Affairs schools and schools operated under contract pursuant to the Indian Self-Determination and Education Assistance Act of 1975 be extended to provide for such instruction regarding alcohol and drug abuse to students in kindergarten and grades 1 through 12, and also in public schools now receiving funds under the Johnson-O'Malley Act of April 16, 1934.

The intent of the Johnson-O'Malley Act was to enhance education, promote social welfare, and provide relief of distress among Indians. Instruction in the harmful effects of alcohol and drug abuse through carefully structured educational programs in the public schools with significant Indian student populations would be entirely in consonance with the stated goals of the Johnson-O'Malley Act.

Recommendation No. 2, that the alcohol and drug abuse newsletter provided for under section 206 of the proposed act include guidelines on establishing the educational programs envisaged, with references to the pertinent parts of the Code of Federal Regulations and related directives, and that sufficient copies of the newsletter be made available for distribution to all affected components of each tribal organization, as well as to the public nontribal agencies having collaborative roles in the program.

Recommendation No. 3, that a clearly delineated source of funding on a continuing basis be provided for the training programs alluded to under title III, Family and Social Services, of the proposed act.

Recommendation No. 4, that alcohol and drug abuse treatment facilities, including emergency shelters for Indian juveniles referred to under title IV, Law Enforcement, of the proposed act be federally funded and adequately staffed with professionally trained personnel.

Recommendation No. 5, that specific guidelines for the preparation of the study directed under title V, Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation, be provided promptly to the participating tribal councils by the Director of the Indian Health Service.

Recommendation No. 6, that alcohol and drug abuse treatment programs be made available for all tribal members and not just juveniles.

In the opinion of the Southern Ute Tribal Council, the sum of $5 million specified in section 603(a) is an unduly modest sum in relation to the number of tribal groups expected to participate. Nevertheless, if section 603(b) is liberally interpreted by the U.S. Congress and the Presidential administration, the procedural mechanisms for fulfilling the goals of the proposed act are not beyond the scope of practical achievement.

On behalf of the Southern Ute Indian Tribe, we appreciate this moment to be heard.

Thank you, Congressman Bill Richardson and members of the committee.

Mr. RICHARDSON. I want to thank you, Mr. Baker.

Before proceeding any further, I would like to recognize some people I notice in the room that I think deserve to be recognized. I know my friends from Sandia are here, and I note some of the leaders of the Cochiti Pueblo are here. And I wonder, Gilbert, if you might recognize some of the other Pueblo leaders that might be in the audience, if they would like to submit a statement for the record.

Mr. **Pena**. Thank you, Congressman. I am sure that they will be submitting statements for the record. We have the Governor from Zia Pueblo, Augustine Pino.

Mr. **Richardson**. Governor, nice to see you.

Mr. **Pena**. Governor Armijo from the Pueblo of Jemez and his staff; Governor Frank Tenorio from San Felipe. Have I missed any other Governors?

Mr. **Richardson**. Well, Regis Pecos, of Cochiti, is there, and he is something.

Mr. **Pena**. Oh, I thought he was a Senator.

Mr. **Richardson**. He is a Lieutenant Governor. He is always running for something.

Mr. **Pena**. The delegation from Santa Ana includes the Lieutenant Governor, Roy Montoya, and we also have the executive director from the Office of Indian Affairs for the State of New Mexico, Mr. Joe Little, and Regis is his right-hand man.

Mr. **Richardson**. So that is what Regis is doing now? OK. I want to welcome all of you——

Mr. **Pena**. One more. We have the Lieutenant Governor from Sandia, Ed Paisano, standing in the back.

Mr. **Richardson**. Yes, I see Ed.

Is the Governor of Sandia also here? Well, I just want to recognize so many people here, and the statement will be open for the record. And I think toward the end, if any of you Governors, out of courtesy, would like to make an official statement, an informal statement, we will certainly make the time for them.

Mr. Baker, I notice here it is Chris Baker. I called you John, did I not?

Mr. **Baker**. Chris Baker is the chairman of our tribe. He was unable to attend.

Mr. **Richardson**. So I am correct? You are——

Mr. **Baker**. I will have to wait 2 more years before I become chairman.

Mr. **Richardson**. You ought to get together with Regis Pecos. I hate to pick on Regis, but he is a dear friend and a young Native American leader that I know is going to go very far in government, and I just wanted to recognize him.

Ms. Peabody, I am sorry to steal your thunder. Do you want to say anything?

Ms. **Peabody**. I don't have anything to say at this time.

Mr. **Richardson**. I want to thank our neighbors from Colorado for coming down here. I believe in Phoenix we will also have representatives of the Ute, so this will be your opportunity. I have no questions. Is there anything further that you would like to add for the record?

Mr. **Baker**. I don't have any further statement.

Mr. **Richardson**. I wish I knew more about the Utes. I know there was a woman in Santa Fe, NM, who was an expert on the Utes, who passed away unfortunately several years ago, Dr. Nan Smith. Do you remember her or any of her writings?

Mr. **Baker**. No.

Mr. **Richardson**. Well, there goes my knowledge of the Utes.

Mr. **Baker**. There must be more experts on Southern Utes somewhere.

Mr. RICHARDSON. I support the Animas La Plata project. That is your water project. We are all for that.

And I see my friends from Santa Ana and from Zia Pueblo. And maybe, Governor Pino, afterward I would like to visit with you on some land issue that the congressional delegation decided last week that I would like to mention to you.

Thank you very much, both of you.

Mr. Ernest House, chairman of the Ute Mountain Tribe? I don't think he is here.

All right, now we will have a Federal panel. We have saved the best for last.

Mr. Vince Little, Albuquerque Area Director of the BIA, accompanied by Charles Johnson, the Education Superintendent at Fort Defiance; Mr. John Buckanaga, Albuquerque Area Director, Indian Health Service, IHS, with Ina Palmer, Consultant for alcoholism; and Mr. Mike Lincoln, Navajo Area Director, IHS.

I would like you all to proceed up to the front and welcome you to the Committee on Interior. I apologize for the delay. Mr. Little, you should act as chairman of this panel, and I will defer to you as to the order of witnesses.

If you could identify for the record those accompanying you, although I mentioned Ms. Palmer and Mr. Buckanaga, Mr. Johnson, and Mr. Little. Is Mike Lincoln here, too? Mike Lincoln has been testifying before Congress extensively the last 2 weeks. I saw him in Gallup.

[Prepared statements of Vincent Little, John Buckanaga, and Michael E. Lincoln, with attachment, may be found in appendix II.]

PANEL CONSISTING OF VINCENT LITTLE, ALBUQUERQUE AREA DIRECTOR OF THE BIA, ACCOMPANIED BY CHARLES JOHNSON, EDUCATION SUPERINTENDENT, FORT DEFIANCE AGENCY, FRANK ADAKAI, AREA SPECIAL OFFICER; JOHN BUCKANAGA, ALBUQUERQUE AREA DIRECTOR, INDIAN HEALTH SERVICE, ACCOMPANIED BY INA PALMER, CONSULTANT FOR ALCOHOLISM: MICHAEL E. LINCOLN, NAVAJO AREA DIRECTOR, JANE COTTOR, POSITION DIRECTOR FOR INCOME SUPPORT, STATE OF NEW MEXICO DEPARTMENT OF HUMAN SERVICES; AND JOSEPH LITTLE, DIRECTOR, NEW MEXICO COMMISSION ON INDIAN AFFAIRS

Mr. VINCENT LITTLE. Good afternoon, Mr. Chairman. My name is Vince Little. I am the Area Director for the Bureau of Indian Affairs in the Albuquerque area.

I would like to introduce Mr. Charles Johnson, on my left, who is the Agency Superintendent for Education at the Fort Defiance Agency, and on my right, Mr. Frank Adakai, Area Special Officer, who will assist me in answering any questions you may have regarding the BIA's education program and the Bureau's law enforcement program.

We appreciate the opportunity to be here today to talk about the very serious problem of Indian juvenile alcohol and drug abuse.

We consider alcohol and drug abuse to be the most serious social and health problem facing Indian people today. Our statistics show that as much as 85 percent of the Bureau of Indian Affairs and tribal arrests in the Albuquerque area involve alcohol or drug abuse. In 1982 and 1983, there were over 16,000 arrests, of which approximately 12,000 were alcohol and drug abuse related.

In 1982, 16 percent of these total arrests were juveniles; in 1983, 14 percent were juveniles. Unfortunately, we do not know how many of the juvenile arrests were alcohol and drug related.

When dealing with juvenile alcohol and drug offenders, a juvenile is taken into custody under four conditions: One, a court order; two, if in immediate danger due to abuse or neglect; three, if there are no parents or guardians; or four, when a juvenile has committed a crime.

Officers are required to notify the juvenile's parents or guardians as soon as possible after the juvenile is taken into custody. The court-designated agent or social services agency is promptly notified in neglect and abuse cases. If juveniles are incarcerated in detention facilities, they are required to be detained in a separate room or cell from adults and adequate supervision is to be provided 24 hours a day.

We do not have facilities at all of our jails to provide separate holding cells for adults and juveniles. When such facilities are not available, officers transport juveniles to the nearest juvenile holding facility, which is generally operated by the State of New Mexico. These arrangements are made through agreements between district and tribal court judges which provide for billing and reimbursement on a daily service basis.

The Bureau of Indian Affairs does not have any facilities specifically designated for the treatment of alcohol and drug abuse problems. We do, however, work with Indian Health Service personnel and the tribes when possible to coordinate services.

Most tribes build upon Indian Health Service initiatives, using local programs or traditional approaches identified locally. In addition, the Bureau adapts many of our programs, such as law enforcement, social services, probation programs, and so forth, to accommodate tribal or Indian Health Service initiatives, which vary from tribe to tribe.

For example, the Indian Health Service provides immunization for childhood diseases and maintains a nursing station either part or full time at most Bureau schools. Where nursing facilities are not available, the school personnel provide transportation for the student to the nearest IHS facility.

The teachers, we feel, have the best opportunity to recognize health-related problems in our students and frequently refer students formally or informally to IHS for medical services ranging from eye examinations to psychological testing. Referral procedures are worked out with the appropriate IHS facility.

The Albuquerque area has 13 schools and 1 dormitory, serving approximately 2,840 students. Each school is required to provide health education as part of its curriculum and must include alcohol and drug prevention as part of that curriculum. Since the development of the program is a local school decision, the programs, of course, vary significantly.

Frequently programs are developed in coordination with the local IHS representative and the tribe and may be as simple as including a unit on the subject as part of the health curriculum or as extensive as having speakers and special materials in each classroom throughout the year.

An example of one of our more extensive programs can be found at the Santa Fe Indian School, which is operated by contract with the all Indian Pueblo Council for grades 7 through 12. Two full-time counselors are available to the students at all times. Individual counseling and peer group counseling are provided, as well as prevention information and evening programs designed to keep students involved in constructive activities.

The program, although primarily known for its successful intervention techniques, recognizes the potential abuser as well as the student who may be an habitual user. In this regard, the school is doing an excellent job.

I might add, in closing, that during the month of June both the Institute of American Indian Arts and the Southwestern Indian Polytechnic Institute are hosting workshops on alcoholism. These workshops are designed to provide training specifically for alcoholism counselors and school counselors.

This concludes my prepared statement. My staff and I will be happy to answer any questions that you may have, Mr. Chairman.

Mr. **Richardson**. Thank you very much, Mr. Little.

Before you proceed, I saw Mary Little leave, another Little who was very instrumental in setting this hearing up. And Mr. Pena, I hope you thank her for me, on behalf of the committee, for her help in setting this up.

Who is going to be your next witness?

Mr. **Vincent Little**. Mr. Buckanaga.

Mr. **Richardson**. Buckanaga, is that the right way to say it?

Mr. **Buckanaga**. Buckanaga. I am from the Norwegian-Scandinavian State of Minnesota, a transplant.

Mr. **Richardson**. Are you a Swede?

Mr. **Buckanaga**. A smoked Swede.

Mr. **Richardson**. Welcome to this committee.

Mr. **Buckanaga**. Congressman Richardson, members of the committee, my name is John Buckanaga. I am director of the Albuquerque Area Office in the Indian Health Service. With me is Ina Palmer, principal consultant for the Albuquerque Area Office of the Indian Health Service. Mrs. Palmer will present to you our prepared statement, which states the seriousness of the growing problem of alcohol and substance abuse that affect our Indian youth.

Following Mrs. Palmer's statement, we wish to submit to you for the record our official written testimony.

Mrs. Palmer.

Mrs. **Palmer**. Good afternoon, gentleman. I seem to be the only blue-eyed Indian at the table, and I also am the only woman at this table, but I am a Sioux Indian from Prime River, SD, and I am also a registered nurse. I have been with the Indian Health Service in the Albuquerque area since 1968.

Mr. **Richardson**. I am reminded that Frank Ducheneaux is from South Dakota. One of the coauthors of one of the bills, Mr. Daschle, is from South Dakota. So, welcome to this committee.

So is the minority counsel here. I want to be bipartisan in this effort. He is from South Dakota, also. So it looks like we are all surrounded with Buckanagas.

And welcome. Please go ahead.

Mrs. **Palmer**. Thank you. I would like to just briefly highlight some of the things that we have in our statement.

The problems with Indian youth and alcohol are not only understated and underreported, but I would also like to add that we have found they are underserved by the Indian Health Service.

Our data across the board in the Albuquerque area shows that the drinking age starts from about age 10 to 14. And our clients state that they started having serious drinking problems or serious problems with alcoholism at around the age of 19.

The area mental health data reports that one-third of their services are directed toward the Indian youth. These are alcohol-related problems and stresses undergone by families and by youth.

One friend of mine, who is an IHS employee in the Phoenix area and who will be testifying before your committee tomorrow, will probably say this again, but he stated to me one time that it appears that neurosis, alcohol and drug abuse, and psychosis appear to be diseases of the young Indian in his or her productive life until about age of 40.

Another colleague of mine, Judy Claymore, who works in my office said that if a young Indian male or female could make it up to the age of 25, he or she should be congratulated for living so long.

Our data also show that, as far as youth are concerned, we appear to be underserving the youth in alcoholism. If you will look at our data, it appears that way.

But if you were to look at the results of alcoholism in our data which are not included in this statement, the trauma, injuries, homicides, suicides, gastritis, sleep disorders, allergies, asthma, headaches, these are all results of alcoholism, either directly or indirectly affecting that youth. We would be spending a great deal of money on youth if we were to include these statistics in our statement.

The IHS data that we have submitted also show that alcohol dependency, DT's, pathologic intoxication, detoxification, cirrhosis in youth under age 18 is very, very high and very costly. And you need to understand that in order to get these kinds of health problems, you really have to start drinking at a very young age and start drinking very heavily at a young age.

I included in the table on cirrhosis—and I am glad I did, because earlier in the testimony you were asking about young females and alcoholism. But if you will look at the data on female alcoholism and cirrhosis, you will find that young females are starting to die of cirrhosis between the ages of 15 and 24, and they are dying at a rate that is higher than that of their male counterparts during that age.

That means that the females are dying—well, the data show that they are not drinking as much, and they are not drinking at as early an age, but evidently they are drinking or becoming alcoholic at a faster rate and developing those pathological disorders at a faster rate than the young males.

Our budget in the Albuquerque area for fiscal year 1985, for alcoholism treatment that goes to all of the tribes for alcoholism treatment, our budget this year is $1.8 million. I need to tell you that no money from that $1.8 million is spent for administrative costs as far as that program is concerned.

My salary, the contracting officer's salary, and my secretary and my staff are not supported from that $1.8 million. One hundred percent of these funds go to the tribe for services.

Mr. **Richardson**. Do you mean to get funded through just straight BIA——

Mrs. **Palmer**. Out of the Indian Health Service. The Indian Health Service has to put up the money for my salary and my expenses.

Mr. **Richardson**. Right before your appearance before this panel, I received a letter from Juan Vigil, who regrettably couldn't be here at 1:30. Apparently, the Governor has asked him to met with a number of people in the legislature on my recent action to close 7 of our 11 income support field offices, and he is not here. He is submitting a statement for the record.

And he has asked Ms. Cottor, position director for Income Support, to represent him and to attend the hearing.

Is Ms. Cottor here?

Would you step up, Ms. Cottor, since we are dealing with Government witnesses, and include yourself in the statement?

Let us proceed then. You didn't conclude, did you?

Mrs. **Palmer**. No. I didn't conclude.

The $1.8 million goes for funding 15 alcoholism programs in the Albuquerque area. Only 15 percent of those funds are being spent for youth and prevention. There are two programs on this list that are geared to youth and prevention activities, and that is the SIPI Alcoholism Program and the Intertribal Heritage Project in Denver, CO.

Most of those programs have been traditionally geared to serve the older male client, who is around 40-years-old and has been drinking for 15 to 20 years. And so that program is hardly an environment for the younger clients to get services and also for female clients.

We were also asked to talk about our referrals in our Indian Health Service to alcoholics. Our referrals in the Albuquerque Area Indian Hospital is done on a community services level. The Albuquerque area alcoholism programs all have a letter of agreement with their respective service units, where they provide referral services and medical services to the alcoholic clients.

Some of the service units in the Albuquerque Area Indian Health Service have provided physicals for the alcoholic patients, as well as, inpatient community care, and also they have provided training for the program, and also consultation.

In one service unit, the Mescalero, a physician actually goes 1 day a week and provides consultation to their respective alcoholism program.

As far as our relationship to the Bureau of Indian Affairs, the tribal policy and judges, and so forth, that is also done on a community level, where the alcoholism program has negotiated agreements with their respective law enforcement agencies to get referrals for clients and treatment.

I might say that 50 percent of the clients that are now in treatment are referrals from the tribal courts and the police, and it is even higher for women and youth. It seems as the women and youth do not get into treatment until they start getting in trouble with the law.

As far as preventive activities are concerned, for the past 3 years the Indian Health Service has been putting a great deal of emphasis on primary prevention. In the Albuquerque area we are presently working on a 5-year prevention plan for our communities.

Our emphasis will probably be—because we haven't developed our plan yet, in fact, we just had a meeting on it this morning—will probably be geared toward healthy lifestyles, the preventing of accidents, the use of seatbelts, and nonuse of alcohol, moderation in eating, alcohol abuse, no smoking, et cetera. Our plan is not yet developed.

Mr. **Richardson**. Are you at all involved in that physical fitness program at Zuni, which has received so much publicity. Is that your doing?

Mrs. **Palmer**. That is not my doing. That is the Indian Health Service's doing.

Mr. **Richardson**. Is that Buckanaga's doing? That is a very good program. I want to give credit to whose ever idea that was.

Mr. **Buckanaga**. It was a joint effort, initiated primarily through the initiative of the headquarters national level; but the credit due should go to the Zuni Services and to the community, and the tribal government also is participating.

It is a pueblo community effort, initiated by Joe Nevers.

Mr. **Richardson**. It has had a remarkable success rate, and it seems that it is the kind of thing that we are talking about that we should do more extensively that relatively doesn't have as much cost to it.

What is the cost of that program?

I see your budget for Zuni is—I think it is $91,000 I saw, $92,000, and I am sure it's accomplished by a minimal amount of that.

Is that accurate, John?

Mr. **Buckanaga**. That is fairly accurate, yes, but there are other supporting dollars. The tribe had added some dollars to it, so it is a little higher budget. In addition to that, it might be made known that the Zuni Hospital is 100-percent smoke free?

Mr. **Richardson**. Smoke free?

Mr. **Buckanaga**. One hundred percent. If you want to smoke, you have to go outside of the building and away from the north wind.

Mr. **Richardson**. What if you are a smoke addict?

Mr. **Buckanaga**. You have to go outside and smoke.

Mr. **Richardson**. It sounds like that is a physical fitness program that we should incorporate in the House of Representatives.

Mrs. **Palmer**. I might add that that the Zuni Service Center there are only two people that smoke, and one of them has since quit and we are working on the other lady.

Mr. **Richardson**. So it is a lady?

Mrs. **Palmer**. Yes, a non-Indian, a white lady.

Mr. **Richardson**. That explains it, then.

I should discuss with you this disparity between men and women. I have a document that shows the low incidence of women and alcoholism, and I didn't make these statistics up when I said that it is more a male problem. But you have shown me some—I think John Buckanaga has some——

Mrs. **Palmer**. There is a high incidence of cirrhosis. It is higher than in the male.

Mr. **Richardson**. In the Albuquerque Indians, 72 to 76. So it seems that in New Mexico we are not conforming with the national average.

Mike Lincoln, are you next?

Mr. Little, who is your next witness?

Mr. **Lincoln**. Thank you, Congressman.

The last time that we saw you in Gallup, it was also in the area of health. I think this fits properly into that context, also.

In my young career with the Indian Health Service, I have now had two unique opportunites. One of them was to be allowed to testify for the Navajo Tribe. It is a little unusual that a Government witness be allowed to do so.

Mr. **Richardson**. This was in Gallup, also?

Mr. **Lincoln**. I did that in Gallup.

The second time I found myself testifying at the Bureau of Indian Affairs, which was an equally unique experience, and I think one that, given the subject that we are here to talk about, one that should occur more often.

I have submitted a statement to the committee.

Mr. **Richardson**. Without objection, it will be inserted into the record.

Mr. **Lincoln**. Then I will very briefly make my comments. The first comment is that I am increasingly encouraged by the willingness of the Congress to prioritize preventive health programs at least on an equal basis with acute care programs. I am not saying that the acute care programs should not continue and are not needed.

As a matter of fact, we have many funding needs for our acute health care problems. I am saying tough, that the emphasis and the focus on preventive health, that for you to focus on alcoholism and youth is noteworthy.

And I think that this focus, if indeed carried out by the Indian Health Service and by the Bureau, by the Indian tribes and by other providers of health care of other people who interact with Indians, that you will see a payoff 5, 10, 15, 20 years from now that would not have been otherwise possible.

My written testimony focuses on health problems that are in consonance with alcoholism. My intent was not to focus on the acute care system, but to highlight those health problems, because if we are going to have a preventive health program, we need to establish a base line.

And if a preventive health program is effective over a period of a number of years—and with health programs, it will take a number of years to measure the effectiveness—we should be able to indeed evaluate those programs and measure their success.

In fact, the health plan of the Navajo Tribe outlines a number of goals with alcoholism. I have brought copies of the master health plan, and I have not submitted those for the record because I believe the Navajo Tribe will do so, but they may be helpful to the committee.

They deal specifically with alcoholism and some objectives that have been indentified——

Mr. RICHARDSON. Why don't we insert them into the record right now? I don't believe that they were submitted as part of the Navajo testimony.

Mr. LINCOLN. I would like to take credit for that, but I believe that I cannot do so. The Navajo Tribe has a very effective, a very knowledgeable health department, and they have developed those objectives.

[EDITOR'S NOTE.—The above-mentioned master health plan may be found in appendix II following Mr. Lincoln's prepared statement. Document entitled "Attachment A."]

Mr. LINCOLN. I think the most important comment that I would like to make is that our facilities in our Indian health care program on the Navajo, we have become known for two things. One of them is that we have an outstanding maternal health care program. It has produced infant mortality rates that are, at least for the first month, on of the lowest mortality rates associated with infants in the United States.

We are also known for our automobile accidents as being the leading cause for our mortality. One of the leading contributors to the workload in morbidity is accidents, and of course, most of those accidents are related to alcoholism or are alcohol related.

The objectives that have been given to you for the record address primarily those accidents and the kind of success that we would like to see on the Navajo.

I would also like to see a competition develop between the acute care programs and preventive health programs. I believe they most coexist. You cannot turn one off and turn the other on without severe consequences to the health system and to the people.

I do think, however, that there can be some reprogramming occur, at least in the thinking of the Indian Health Service, and an additional priority added to our thinking, and that would be preventive health programs.

Either alcoholism and the prevention of alcoholism are a priority to the Nation, to the Congress, to the Indian Health Service, and to the Indian people or they are not.

It is my opinion that your bill will go a long way toward making this health problem a priority. I believe that reprogramming efforts within the Indian Health Service are going to have to take place. We certainly will be investigating that and initiating that within that little area.

I also believe, of course, that given even that slow change, that there must be additional emphasis, additional resources provided to accelerate the needed changes, in order that we may impact this year for the next 40 years, rather than have to wait for a much slower process.

The last two statements that I would like to make are that the Navajo population, 15 percent of the Navajo population is under the age of 17.6 years. That is 80,000 people under the age of 18.

We are going to continue to have problems associated with this group. We are going to continue to have that group. We are going to continue to have that population grow at about 2.5 percent a year in the Navajos' case.

And of those in this group having special health problems, alcoholism and other drug abuse problems being a critical factor in the health of these individuals. I believe that if we can help them as youths, that down the road, they will have less health problems than if we do not focus on the preventive health aspects, the wellness aspects, and the health promotion aspects that should be included in an overall health program.

I support the statements that were made by previous witnesses, and the support is in the form that we must develop new technologies, we must incorporate new modes of addressing alcoholism and substance abuse problems in all age groups.

There must be a comprehensive program for all of it, the prevention and the treatment of patients within the context of we providing health services within the Indian community.

If those programs can be developed and if the Congress mandates, we at the Indian Health Service, the Bureau of Indian Affairs, and the State health department and, above all, the tribes, then I believe we can be successful and we won't have to wait 5 or 10 years to get the job done.

That concludes my statement, and I will answer any questions that you have available.

Mr. Richardson. Thank you, Mr. Lincoln.

Mr. Vincent Little. Mr. Chairman, the director of the Indian Health Service in Albuquerque, Mr. Buckanaga.

Mr. Richardson. He has already made a statement.

The gentleman on Mr. Lincoln's right has not made a statement.

Mr. Vincent Little. These are simply resource people.

Mr. Richardson. Well, then let's go to Ms. Cottor.

Mr. Richardson. Ms. Cottor, is there anything you wish to say? We have Secretary Vigil's statement, and he has communicated with this committee.

I would just like to give you the courtesy if there is anything you would like to add. I just wanted you up with this panel.

Ms. Cottor. I don't think that I have anything additional to add. I would just, as reflected by his remarks, that he is actively working with the Indian tribes in the State of New Mexico to try to improve our communications and our services that are available to the Indian youth.

Mr. Richardson. You know, Ms. Cottor, one statement that was made by the State's Indian Affairs Council was that they felt that they weren't being cut in, not for the State, but when there were Federal programs, they urged better coordination involving the State Indian Affairs Council in some of these health programs.

I wonder if you would like to say anything. They weren't specific They just said, "Many times we are bypassed."

They weren't bypassed, they said, willingly. But somehow, if we are trying to reduce costs, maybe they should be brought into the scope of these programs.

Ms. Cottor. I really can't add anything meaningful because I am not myself involved in the health area.

Mr. Richardson. Mr. Little, would you just like to comment on that? I won't hold you to any——

Mr. Vincent Little. If I could have the question again?

Mr. **Richardson**. At the hearing in Gallup, a representative of the State Indian Affairs Council—is that the correct name for it, Mr. Lincoln?

There he is. Come over here.

We have just added a witness who made a very good presentation. He is the vice chairman of——

Are you the chairman now?

Mr. **Joseph Little**. No, I am the director of the Commission on Indian Affairs, the State office. What I was referring to was not our office.

What I was directing people to was that there are a number of programs with Federal money that have Indians earmarked for that, as well as, special appropriations of the State legislature.

Not all of those bills have passed, but a couple of them have passed with several hundred thousand dollars earmarked for elderly programs.

Some of those programs within the tribal communities will be funded out of this, but that was only because the tribes specifically requested it.

But what I am saying is that, from what I have seen, there hasn't been sufficient coordination between the Federal programs and the State programs in trying to implement a number of these areas. Now that does occur within some of the agencies, but not total unity.

And in line with that, as my area director has pointed out, the point should be made that there needs to be an approach to dealing with the health issue on a more—we like the term "holistic" basis. That is, again going to our area of coordination and going back to the overall programs dealing with it, there needs to be a way to deal with the occupational end, with the health end, and dealing with the alcoholic and the practical, physical problems with that.

In line with that, what we would like to propose and what we would like you to consider is making it a pilot program. We have a specific county in mind with an Indian population and we have also got some specific problems. We have also got cooperation from the community involved in this. And at some point in time later we would like——

Mr. **Richardson**. What county are you referring to?

Mr. **Joseph Little**. We are looking at Sandoval County.

Mr. **Richardson**. That is fine with me. Just stay north of Albuquerque.

Would you identify yourself for the record?

Mr. **Joseph Little**. My name is Joseph Little. I am the executive director of the New Mexico Commission on Indian Affairs.

Mr. **Richardson**. There are a lot of Littles running New Mexico programs here, aren't there?

Ed, is nepotism rampant here or what?

Mr. **Vincent Little**. No relation, unfortunately.

Since Mr. Joseph Little has taken over the directorship, we have become more involved in at least making an effort to coordinate our other programs, such as economic projects, and trying to cooperate as much as possible with the State.

Mr. RICHARDSON. Mr. Little, what percentage of your programs, BIA, Indian Health Service programs, are directed toward Indian juvenile alcoholism in New Mexico?

Mr. VINCENT LITTLE. I am sorry to say, I can probably say none, zero.

Mr. RICHARDSON. Zero?

Mr. VINCENT LITTLE. Yes; we do not have any funding for this particular program. This is out of Indian Health, if I am not mistaken.

Mr. RICHARDSON. That is our most serious problem. I wonder why that is happening?

Mr. VINCENT LITTLE. We are recognized as the funding agency or the lead agency, and we try to supplement it as much as we possibly can with technical assistance and, with a lot of the programs, social service programs, or educational programs. But as far as direct dollars, no.

Mr. RICHARDSON. OK. If this bill is passed or any version of this bill, you would be the lead agency?

Mr. VINCENT LITTLE. That is what it is usually called, yes.

Mr. RICHARDSON. Do you like that idea?

Mr. VINCENT LITTLE. I have no problem with it, but again I think I would have to go with some of the recommendations that have been set forth by the tribal leaders here today in order to carry out the responsibilities, as such.

On the other hand, I have no problems with the Indian Health Service carrying it and we, in turn, helping out as much as we possibly can.

Mr. RICHARDSON. Well, obviously I could sit here and ask very pointed questions, but I don't want to beat up on the Indian Health Service. I know what the problems of the Indian Health Service are. We have two Indian Health care bills that we have reauthorized in the last 6 months in two of my committees, and I don't need to be educated on that and I am sure everybody here knows the problem.

I guess my question is, which you really have not answered, any of you, although I think Ina did and John did, is, do you support the Indian Juvenile Alcohol Act?

Do you support the enactment of it?

Mr. VINCENT LITTLE. I would probably say personally, yes, along with the recommendations again as made by the tribal leaders or in the cases that would fit in to make it more efficient.

Mr. RICHARDSON. Mike Lincoln, what is your position, on behalf of the Navajo Nation?

Mr. LINCOLN. Well, on behalf of the Navajo Area Indian Health Service, I am always reminded to be careful.

Mr. RICHARDSON. I am not trying to get you in trouble.

Mr. LINCOLN. It should certainly focus on preventive health, focus on the leading health problem among Indians and among Navajos.

We support any effort that can be made toward addressing the problem. We think that if you do it in a preventive health mode, that the impact will be felt in future generations.

But if we continue to operate and have the mentality that our contribution to addressing the problem in our emergency rooms, I think you will continue to see the workload data that we have, and you will continue to see health problems associated with alcoholism for the next 20, 30 years.

Mr. **Richardson**. John, would you like to state for the record your position?

Mr. **Buckanaga**. The Indian youth is probably our No. 1 resource, and the substance abuse, alcohol, drugs, have been a very severe problem, and recently there has been emphasis and recognition of it. There are very limited, accurate studies and research on this.

Everybody is doing some of it, but soon hopefully we can get some coordinated efforts in that respect.

I personally endorse the efforts of Congress to initiate legislation and appropriation, adequate appropriation, to begin to initiate some activity in the alcoholism prevention program for the Indian youth.

Mr. **Richardson**. Mr. Little, have you had a chance to read the BIA Accountability Act?

Mr. **Vincent Little**. Yes, sir.

Mr. **Richardson**. Do you have a position on that?

Mr. **Vincent Little**. A personal position?

Mr. **Richardson**. Personal positions will be deleted from the record upon instructions from the Chair.

[Off-the-record discussion.]

Mr. **Richardson**. Is there anything your two technical assistants might like to add for the record of this hearing?

Mr. **Vincent Little**. They are here primarily to answer any specific questions that relate to——

Mr. **Richardson**. The termination of revenue sharing is going to be very adverse on you; is that accurate?

Mr. **Johnson**. That is at the tribal level. We really don't have too much to do with the revenue sharing.

Mr. **Richardson**. I really don't have any questions on law enforcement. It is obviously an important component, and it was discussed earlier, the use of it as a preventative measure.

Mr. Johnson, do you want to say anything?

Mr. **Johnson**. I have nothing to add. If you have any questions, I will be happy to answer them.

Mr. **Richardson**. No, I think that is it.

I want to thank the witnesses for appearing, and thank you for all the cooperation you have given my office, Mr. Little.

You know, sometimes you get in crossfires between Washington and here, and I am sympathetic to the problem, and hopefully we will correct it someday. We need to do something about the BIA, you know that and I do.

Mr. **Vincent Little**. Thank you on behalf of all of us.

[Whereupon, at 4:30 p.m., the subcommittee was adjourned.]

INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

SATURDAY, JUNE 15, 1985

House of Representatives,
Committee on Interior and Insular Affairs,
Phoenix, AZ.

The committee met, pursuant to call, at 10 a.m., in Courtroom 2, seventh floor, 230 North First Street, Phoenix, AZ, Hon. Bill Richardson presiding.

Mr. Richardson. The Committee on Interior and Insular Affairs will come to order.

I am delighted to be here in Phoenix, AZ, the district of my good friend and colleague, John McCain.

We are here to hear testimony on two bills of enormous importance, H.R. 1156 and H.R. 2624, dealing with Indian juvenile alcoholism and drug abuse prevention.

H.R. 2624 is authorized, by my friend and colleague, Mr. McCain, who has demonstrated, I think, in his term in Congress to be one of the most knowledgeable and sensitive of Native American issues; and I am delighted to be here in Phoenix.

I am from neighboring New Mexico. My name is Bill Richardson. I represent northern New Mexico, the largest congressional district with an Indian population, and I have a good part of Navajo in my district, but I would like to say I am delighted to be here with my good friend Congressman McCain.

John.

Mr. McCain. Thank you very much.

I would like to thank you very much, Bill, for being here.

Many Arizonians are not aware that Congressman Richardson, among his many other duties, is chairman of the Congressional Hispanic Caucus, an organization of immense and growing influence in the Congress of the United States.

He was also one of the leaders on an issue which has deep and abiding interest to all of us in Arizona, and that is the Simpson-Mazzoli bill, which we will revisit this year.

I would suggest Congress will probably spend 1 week on the floor of the House on that issue alone.

I am grateful you would take the time to come over from New Mexico to be here on this issue. I recognize the large Indian population in the State of New Mexico, and I am sure you are aware that in Arizona we also have a very large Indian population, as well as 20 reservations.

The issue of drug and alcoholism abuse, has been highlighted nationally. It is a problem throughout our society. It is just as severe on our reservations.

I believe we can only address this problem adequately with the kind of expertise represented by the witnesses you have called here today.

I don't pretend to know the answer to this severe problem that is plaguing our Native American community, but I do know that the situation has reached crisis proportions. If we expect our Native American population to be able to take its proper place in our society, economically and educationally, we are going to have to address this issue and address it immediately.

I am appreciative you would take your time.

I have a statement I would like to submit for the record.

Mr. RICHARDSON. Without objection, it will be submitted.

[EDITOR'S NOTE.—Prepared statement of Hon. John McCain may be found in appendix III.]

Mr. MCCAIN. Also, my colleague Jim Kolbe down in Tucson, is not here today, and he has submitted a statement that I would like included in the record with your permission.

Mr. RICHARDSON. Without objection.

[EDITOR'S NOTE.—Prepared statement of Hon. Jim Kolbe may be found in appendix III.]

Mr. MCCAIN. Thank you again, Mr. Chairman, for being here. I look forward to hearing from the witnesses.

Mr. RICHARDSON. Thank you very much, Congressman McCain.

We will move into the hearing, into once again an important and sensitive issue. It is our hope the Committee on Interior will mark up this legislation, will consider it for votes and amendments in the months ahead; hopefully this year before the session of Congress ends.

We had dramatic and interesting testimony in Albuquerque yesterday on the two bills, and the issue is very clear. There is a great need to do something about the problems of Indian youth alcoholism.

The debates will center on the kind of treatment, the kind of prevention, what are the Government vehicles to handle it, the cost of the program, the origination, and we are delighted to hear from several witnessses today.

What I would like to just emphasize at the start of the hearing is that all of your statements will be inserted in the record on a permanent basis, and I would ask each witness to submit their prepared statement and then, because of the number of witnessses, 19, we would like to have you summarize your statement in 5 minutes or less so that Congressman McCain and I will have a chance to question you.

I think we learn more in the question and answer period and that kind of dialog. If you could remember that, to summarize your statement. Your statement is inserted fully in the record and distributed to all members of the Interior Committee, and all the staffs of the Interior Committee; and for this reason I urge you to do so. We will have a better hearing that way.

Our first witnessses will be Mr. Frank McCabe, the secretary of the Colorado Indian Tribes.

Mr. McCabe is accompanied by Ms. Mona Fernandez, who is director of the Alcoholism Program.

Mr. McCabe, Ms. Fernandez, welcome to this committee, we look forward to hearing your statement.

[Prepared statement of Frank McCabe may be found in appendix III.]

PANEL CONSISTING OF FRANK McCABE, SECRETARY, COLORADO RIVER INDIAN TRIBES; AND MONA FERNANDEZ, DIRECTOR, ALCOHOLISM PROGRAM

Mr. McCABE. Good morning, Mr. Chairman, distinguished panel.

Mr. RICHARDSON. Could you all hear Mr. McCabe in the back?

I see heads nodding negatively.

We have technical difficulty, but we are not going to hold off. You are going to have to talk very loud, both of you. So pretend you are addressing the chapter and trying to get some political point across. That is how we will proceed.

I think those folks back there, if they maybe move up a little bit will hear you better.

Go ahead, Mr. McCabe.

Mr. McCABE. My name is Frank McCabe. I am from the Colorado River Reservation, in the farming area. Our reservation—Mr. Chairman, first of all, as you said previously, in your previous statement, we do have a prepared testimony.

I would like to enter it in the record as if I had read it or given it.

Mr. RICHARDSON. Without objection.

Mr. McCABE. Without further ado, I will give you a little background.

One of the important things we were told is give statistics. Our reservation is over a quarter million acres and located west from here. By car, 3 hours away, by air it is about 40-minute flight.

We have a population of a little less than 3,000 and we have in the area of 866, 11- to 18-year-olds, which this bill we understand addresses. We have 400 males and a little over 450 females.

So you can see from newborns to 18-year-olds, we have got a little over 850 young individuals. This represents about 36 percent of our total population. And our reservation is in three counties, and in two States.

Basically, in short, this bill that is being proposed for these field hearings, H.R. 1156, the Colorado River Tribes are very much in support of, with some qualifications.

Bear in mind that our reservation is in California. There are areas that are Public Law 280 affected, so there are some language that may have some adverse impact to them.

One of the first things I want to say, we do have a program we refer to as behavioral health services, and we do have various contracts, various grantors that help fund our program.

One of the things, when I used to be a director of the adventure-based recreation program—and currently now Ms. Fernandez is the executive director of that particular program—one of the problems they face is when this concerted effort to get accorded services between BIA and Indian Health Services, one of the dilemmas our grassroots people have is that they are overwhelmed with various forms.

A case in point, in our reservation one client requires 15 papers just to initiate. So if the intent is to help assist individuals, young folks, this more or less compounds the problem of devoting more time to paperwork. We don't mind doing paperwork, only if it is necessary.

So one of the things in your effort to get coordinated services, we would like to see that, some innovative ways to develop a form that can be used, very functional, and somehow you measure management. So I want to emphasize that.

In our statement, some of the things that we highlight in our testimony is most of the titles. Like, for example, title II, we support in that effort where there are going to be moneys available to help have training for individuals that are in direct contact with students.

In the title III, we also have no objection, we commend the drafters of this particular bill. There are going to be efforts to utilize talented indiviudals that are going to work with young people.

Under title IV, law enforcment, we would like to recommend a change in there. Nothing really significant other than to ask that in our interpretation it makes it look like it is mandatory for tribes to put children in areas where they really ought not be. So we would like to have the more optional.

So, in our statement, we do recommend some changes. I think there is a part there that says drugs or alcohol, this is under title IV, section 402A1, line 6, to be changed to read, "Drugs or alcohol shall, when appropriate, detain such juvenile in a temporary emergency center."

We recognize that in section 402 he also recognizes a real good point. That point makes emphasis on guideline or regulation can supersede tribal government. That is good.

There are tribes that have a juvenile code. When these laws are developed it will at least be cautious, sensitive to tribal laws that exist.

Under title V, I think those of us know the very basic cardinal rule is any time you relocate an individual it disrupts their mental health and their society association. So if there are going to be an establishment of any facilities or treatment centers, one of the things we like to see is close proximity to the reservation.

One other thing in closing, one other thing we like to mention, is in the reading of the bill it says, it is going to set aside $5 million. In the statement of the entire tribal council of Arizona, there are recommendations I read to various reservations and recommend $5 million may not be very feasible.

I know Congress is really frugal and prudent, so any increase in that, I think ITC recommends $30 million. So——

Mr. **Richardson**. How much?

Mr. **McCabe**. 30 million. I just leave it at that.

Given the extent of the problem on the reservation, bearing in mind, we have about 36 percent that are offenders of alcohol and substance abuse; so I would like to thank those drafters.

And I know, Congressman McCain, I have been on record, and I think with your experience in Vietnam you have been deprived of your freedom, I think you know the poor indigenuous people want their freedom. We commend you.

Debbie, I have known forever to continue to advocate Indian people.

Thank you very much.

Mr. **Richardson**. Ms. Fernandez, would you like to say anything for the record?

Ms. **Fernandez**. What I would like to say is that the for the past 10 years I have been working in the area of alcohol and drug abuse with Indian juveniles, and having a bill such as H.R. 1156, being enacted would be of great encouragement to those of us who are directly involved with the major community resources, our youth.

To us it is real important that we provide the kind of support systems in our own communities for encouraging the youth to become healthy, productive citizens, not only for their own tribal people but for the whole Nation.

That is all I have to say.

Mr. **Richardson**. Mr. McCain, do you have any questions?

Mr. **McCain**. Again welcome, Mr. McCabe. It is a good to see you again, and Miss Fernandez.

I was interested, you said there is around 36 percent who are offenders. Is that the 36 percent of the male or female or both?

Mr. **McCabe**. That is a total of those females and males between the ages of 11 and 18.

Mr. **McCain**. Thirty-six percent?

Mr. **McCabe**. Right.

Mr. **McCain**. Mr. Chairman, I don't know of a more graphic demonstration of the need here than that. By the way, I think we may work out in the final legislation language such sums as necessary. The better that Chairman Richardson and I can educate the other Members of Congress as to how serious this problem is the better our chances are for increased appropriation.

Thank you, Mr. Chairman.

Mr. **Richardson**. Thank you, Mr. McCain.

I have just one question, and that is in our hearings in Albuquerque there seemed to be a little bit of division between orientation of the treatment, should it be more directly youth oriented and more through family treatment and guidance? In other words, family—I hate to put it this way, but family versus youth.

Do you have any views on this, Mr. McCain or Miss Fernandez?

Mr. **McCabe**. Mr. Chairman, the council, although it didn't really discuss their philosophical views, from my standpoint I think there ought to be emphasis on family. Family is the ones that are the very foundation.

I think there ought to be some type of a dual attack on this. Of course, the focusing point we understand is juvenile.

Mr. **Richardson**. I want to thank you both for your fine testimony. As we stated, it will be inserted fully into the record.

I wish you the very best, and please stay in touch with this committee as we proceed with Mr. McCain's legislation and the other bill we have, because we hope to get it done some time this year; because we know the problem is very serious.

Thank you both.

Our next witness is Mr. Norman Austin, chairman, Fort McDowell Mohave-Apache Tribal Council. And Mr. Austin is accompanied by Louis Hood. I would like to welcome both witnesses.

[Prepared statement of Louis Hood may be found in appendix III.]

STATEMENT OF NORMAN AUSTIN, CHAIRMAN, FORT McDOWELL MOHAVE-APACHE TRIBAL COUNCIL, ACCOMPANIED BY LOUIS HOOD

Mr. Austin, is that you?

Mr. **Austin**. I am Mr. Austin.

Mr. **Richardson**. Please proceed. You know the ground rules we would like to establish. We look forward to your testimony.

Mr. **Hood**. Good morning, gentlemen. I will just briefly summarize the statement that has been typed out.

I, Louis Hood, have been requested by the Fort McDowell Tribal Council to testify on H.R. 1156, Indian Juvenile Alcohol and Drug Prevention Act. Fort McDowell is a Yavapai community with a population of 398 people and is located 28 miles northeast of Phoenix.

Over one-third of our population, 140, is under the age of 18. Therefore, one can see that we stand to benefit greatly by H.R. 1156 if it is passed.

Alcoholism and alcohol-related problems are the No. 1 health and social service problems facing our community. It impacts our children in their completion of schooling. And disruption can be evidenced by the large number of family members seeking assistance from tribal social service and the high number of calls that our community police must respond to in which alcohol and substance abuse are at the foundation.

It is for the above concerns that we, the Fort McDowell people, support the intent of the law. We would also like to say that coordination of prevention services, which is title I of the act, implies that there are systems already in existence which are addressing this problem.

It is important to note that at Fort McDowell we have few resources available, and what we really lack is financial resources to develop prevention programs for communtiy juveniles in primary and secondary alcohol and drug abuse. It is unclear in title I at what point tribes will be involved in developing coordination agreements with IHS and BIA. This needs to be clearly stated.

For example, in section 101(a)(3), the responsibilities of BIA and IHS in coordinating alcohol and drug abuse need to be outlined, and funds need to be appropriated for this endeavor. No funds have been allocated in this section.

How will this work be funded through current budgets?

Since you have the rest of the statement, I will just go down.

In summary, I would like to comment that this legislation has good intentions for our Indian youth who are our greatest resource. A current unmet need in our community is the development of ongoing positive peer group activities that can be the basis for developing an alcohol and drug prevention program that meets the specific needs of youth living in Fort McDowell.

Mr. **Richardson**. Thank you very much.

Sir, do you have a statement you would like to make?

Mr. **Austin**. No.

Mr. **Richardson**. Mr. McCain.

Mr. **McCain**. Mr. Hood, indeed, you said it is the No. 1 problem on the Fort McDowell Reservation at the present time?

Mr. **Hood**. Yes, it is.

Mr. **McCain**. Overall, you are supportive of this type of legislation?

Mr. **Hood**. Yes, sir. That is correct.

Mr. **McCain**. You are concerned about the amount of funds?

Mr. **Hood**. That is correct.

Mr. **McCain**. I would ask the same question the chairman asks. Should this be a family oriented program?

Mr. **Hood**. Definitely.

Mr. **McCain**. Thank you. I have no more questions.

Mr. **Richardson**. I wanted to ask you a question, Mr. Hood. In page 2 of your statement, you said in sections 204, 205, we concur with the ITC of Arizona comment that they should be changed to include that quote "services developed under this section shall be coordinated with existing local programs."

Could you comment on the coordination of some for these programs and the efficiency with which they are run?

Can we do better in that area?

Mr. **Hood**. The problem we have is that there is really no specific program such as this bill covers. We do have an alcohol program, but it is adult oriented, and some children are included. Therefore, we feel that there is a necessity to address the problem of youth oriented—cover a large number of youth. CHR has a program that covers—does try to include the family, but it is not wide range enough to cover the population involved in here.

Mr. **Richardson**. Also on page 2 of your statement, you made what I think is a very good point about training, and you are recommending there should be a training program, substance abuse training through IHS. I take it the concern you have is that employees of tribal human services also be eligible for that training?

Is that correct?

Mr. **Hood**. Yes.

Mr. **Richardson**. Presently they are not?

Mr. **Hood**. No.

Mr. **Richardson**. Why is that?

Mr. **Hood**. It is on a voluntary basis. I think we should set up a program where people feel they can come together with the help of different bureaus, be involved in it, in educating both adults and the youth. That would be very helpful.

Mr. **Richardson**. Well, I want to thank you both for your testimony. You have obviously put a lot of time into it.

I have never been to Fort McDowell, but I have many friends from that area that are on the Navajo reservation. They tell me it is the second most pretty Native American area.

Is that correct?

Mr. **Hood**. Thank you. I think you would probably be familiar if I mentioned Orm Dam.

Mr. **Richardson**. I want to thank both of you for your very fine testimony.

Mr. **Hood**. Thank you, sir.

Mr. **Richardson**. Our next witnessss will be Mr. Harlan Scott, a tribal judge, Fort Mohave Tribal Council. The Honorable Harlan Scott.

Mr. Scott, welcome to this committee. Your statement will be inserted in the record. Would you please proceed.

STATEMENT OF HARLAN SCOTT, TRIBAL JUDGE, FORT MOHAVE TRIBAL COUNCIL

Mr. **Scott**. Good morning, Mr. Chairman, Mr. McCain. We did not prepare a formal statement to this committee. We will prepare one within the next 10 days and submit it.

When I looked at the stats I didn't quite agree with what I was looking at previously at a prior juvenile justice submittal, so I somewhat informally rejected what I was looking at. So I redid some of the information.

I am Harlan Scott. I am chief judge, Fort Mohave Tribe, which is located in Arizona, California, and Nevada. We are across three States comprising a total of some 11,000 acres in one area.

Only about 5 percent of the area involved is in California except that the majority of the people live in the State of California, oddly enough, in an area that was acquired for housing in California, in the community of Needles, CA. So we are dealing in the Public Law 260 sector. This creates a considerable amount of jurisdictional barriers.

We have set in motion a lot of provisions to overcome these jurisdictional barriers, and have quite successfully dealt with the county of San Bernadino in California, State of California; and on the Arizona side Mohave County and the State of Arizona; and over in Nevada, Clark County and the State of Nevada.

In addition to that, then, we have to deal with our own law and order code, and we have our own police force, and also our own tribal court. We have had a considerable amount of bridging effect with the various entities of the various governmental agencies that we have to deal with in setting up the bridging effect in order to overcome the jurisdictional problems.

There are 805 in population on the Fort Mohave Reservation. There are 273 between the ages of zero to 18. Of this, there are some 120 going to school in the Needles district, and there are 160 going to school over in the Arizona area. And the balance are going to school in either Phoenix Indian School or Sherman Boarding School and other schools outside of the reservation.

So we have got quite a cross section of areas. There are no schools on the reservation.

Of the schoolage children—or rather let me put it this way—of the children that we looked at in the juvenile sector, we do have a juvenile court and probation officer on staff. Of this, we have approximately 150 cases before the court in various alcohol-related problem areas. So we are looking at approximately 40 percent of our children in alcohol-related problem areas.

We are here to support this bill being considered. The Fort Mohave Tribe thinks it is one of the best things that has come before the Indian people for direct resources, for those things that are needed.

I think that it will help bridge a lot of the regulatory barriers we have had to deal with. As an example, I can recall not too long ago, it happened to deal with a situation where we had written a proposal to provide for some structured recreational activities for children between the ages of 13 and 15 when there was structured recreational activities already on programming for those between 9 and 12. We were going to superimpose this program on top of this existing program.

We were going to use staff personnel. We were not going to hire anyone, but we suddenly bumped into a BIA official who—one comment was that you are supporting IHS staff, you are providing IHS staff with personnel, and therefore it is not in accordance with regulations, and will die.

We talked to that man for about 3½ hours. We finally gave up. That program never did go.

I think it is one of the best things that has happened. We have got some refinement to do, I think, in the area.

I was a juvenile judge at the time this occurred at Colorado River Tribes, and I dealt with the youth activities for a long time. I think it is one of the better bills that are being considered because it does give us an opportunity to look at those things that we are most concerned with.

In title II, for instance, the training of the people who are going to be involved in the direction of our children in the alcoholism area are going to be people who are going to be actually educated along the techniques where a lot of times they are placing reformed alcoholics in this area. And although they may be knowledgeable, it is a lot of street knowledge that is not coordinated for a proper direction of our youngsters.

Moreover, I think in title III, the family social services area, now we are getting affiliated services. One of the best things I think being provided for in the community is health respresentatives, requirement for training of those people. We see a lot of extreme reluctance of some of the affiliated services fields to come and be a part of things that concern us in the handling of our youth on the reservation, and alcohol is one of things that concerns us most.

I think it is kind of hard to think about it, but I think at least on the Fort Mohave Reservation, we are looking at second and third generation alcoholism, and I think we need to think about that very seriously.

I think since World War II—the buddy-buddy situation had occurred in World War II—we were able to get out and learn what it was to be among the urban society and learn to do the things that would provide us the mechanism for successes, and those successes means we had to socialize with the things that a lot of times introduced us into this alcoholism difficulities.

But in that same respect, the people that we dealt with there went on their way to their respective areas. We didn't see them anymore but maybe once every 10 years.

But on a reservation you find that the same people that this youngster grew up with is the same buddy that he drank with way back when he was 11 years old, and he still drinks with him here at age 50 and 60 years old.

So the young drinker is now the adult alcoholic. So I think from Fort Mohave we like what we see in the bill now being considered.

That is all I have.

Mr. **Richardson**. Thank you very much, Judge.

Congressman McCain.

Mr. **McCain**. Judge, you obviously have been observing this issue for a long time. Do you feel that the problem has gotten even worse over time, or have you seen any improvement?

Mr. **Scott**. I don't believe we have made any significant successes toward—any gainful means toward doing anything about the Indian alcoholic in the the youth area, primarily because there has never been any direct funding for that particular purpose. I think this is one of the things that this bill will do.

Mr. **McCain**. I mentioned we are now facing a problem of second and third generation alcoholism?

Mr. **Scott**. Yes. On the reservation. Because most of the individuals who were youngsters on the reservation returned to the reservation and remained there, and while they were drinking with their buddies continue to drink.

One other thing that is very alarming to me, and we have made steps to correct that in what we do with our people—and I might mention it because I am in a Public Law 280 area—our code provides for any minor consuming—I can charge any minor consuming under our code.

I bring the adult in with order to show, because why should he not be held for violation, for contributory violations, and if he cooperates with me I won't do anything except monitor him. If he doesn't cooperate with me, I will go ahead and write him up and send him into the country for prosecution, because under Public Law 280, I do not have criminal prosecution jurisdiction.

Mr. **McCain**. It is obvious Public Law 280 does cause a real problem in this legislation that I think we are going to have to address, Mr. Chairman, when we continue refining this legislation.

I would just like to thank you for your years of effort of trying to help this very serious situation.

Mr. **Richardson**. Thank you, Mr. McCain.

Judge, being involved in law enforcement effort and obviously being very sensitive to this issue, I just have two questions. One a technical one, the second one, your view on a specific provision in title IV that deals with law enforcement.

The first is, are you satisfied that this legislation does not supersede any tribal codes so we wouldn't have any problem there?

Second, what is your view of the emergency shelters that are part of this bill?

Mr. **Scott**. To answer the first question. I don't see any problem areas whatsoever. I think it strengthens any trial codes we have in providing the mechanism by which we can work. I don't have any problems with what I see here.

What we have attempted to do in many of the areas that we find some difficulty in placement of our children, we try to work out some of the problem areas. I don't have any problems with the placement facilities. I need to kind of look it over a little more.

Mr. **RICHARDSON**. If you could send us a note on that, too, your views on the temporary emergency shelters that are part of the bill, which I know a lot of folks—I know Congressman McCain and many others have it as a centerpiece of the bill under the law enforcement section.

I personally think it is a good idea, and I commend my colleague, Mr. McCain, and those that have drafted this legislation, because I think too often we are always emphasizing these permanent facilities that are just hospitals, big white elephants that have the big treatment, and the problem is getting worse.

I think 60 percent of the illnesses in the Indian nation and around the country are alcoholism related, and we are making very minimal inroads into this issue, and into this problem, and this is a new idea which I think makes a lot of sense.

Thank you very much, judge, and I commend you for all your efforts.

Mr. **MCCAIN**. Mr. Chairman, unfortunately, I am required to leave to go down to Tucson. I would like to again express my appreciation I think on behalf of many of your friends here in Arizona for your taking time from your busy schedule to be here and conduct these hearings. It is very important and we are very appreciative.

Mr. **RICHARDSON**. I want to thank you, Mr. McCain. I want to once again stress the work you have done on behalf of the Indian people in the Congress. This is your bill, and I recognize you have many pressing commitments, and I, too, want you to know we will continue in a bipartisan way to work together on this and many other issues.

Mr. **MCCAIN**. Thank you.

Mr. **RICHARDSON**. Our next witness will be Bernadine Siyuja——

Is that correct? How did I do there? Did my Navajo come in handy?

From Indian Child Welfare Liaison, Havasupai Tribal Council. I want to welcome you to this committee, Bernadine.

Ms. **SIYUJA**. Siyuja.

Mr. **RICHARDSON**. That is what I said.

STATEMENT OF BERNADINE SIYUJA, INDIAN CHILD WELFARE LIAISON, HAVASUPAI TRIBAL COUNCIL

Ms. **SIYUJA**. I will go over briefly where the reservation is in case some of you don't know. The Havasupai Reservation consists mainly of inaccessible canyons and arid, brown, high plateaus bordering the rim of the Grand Canyon. Our population centers in the small village of Supai.

The village lies on the floor of the Havasu Canyon, 3,000 feet below the rim and 8 miles from the nearest road. Travel to the outside is limited to foot, horse, and helicopter.

The nearest town, Beechstreams, is 75 miles away and has about 1,400 residents. About 176 Supai Tribal members under 18 years old reside in Supai at least part of the year, or about one-third of the population.

About 17 Supais under 18 attend boarding schools in Phoenix or Riverside, CA, and reside at home during summer and winter breaks. About a dozen school dropouts under 18 reside on the reservation most of the year.

Dropouts and boarding school students home for the summer lack employment opportunities or other wholesome diversions and generate much of the social problems in the village.

Children lacking wholesome activities outside of the school fall into delinquency. With few socially acceptable amusements available, many turn to using alcohol, marijuana, or other substances.

As I said, the recreation activities are limited. And the village being so small, they only have one basketball court, which most of the kids are more into.

And you see that a lot once you come into the village, basketball. They only have one—in order for all the kids to take their turn, some go late into the night because of only one of the courts that they have there.

The existing services we have in Supai is the social services and the new program, ICWA, The Indian Child Welfare Act, which just started. Every family in Supai is touched directly by the workers services in some way.

The ICWA workers expect participation rates for services to increase significantly next year as people come to realize the benefits of the services, the ICWA workers are routinely provide.

About 40 children go to the court because of past experiences, and these children will be receiving counseling or recreational activities with the ICWA workers, about 79 children, the first through eighth grade, are receiving drug counseling regarding alcohol and substance abuse with ICWA workers. And the services are well coordinated with the BIA police authorities.

Fourteen children and their parents receive special counseling in connection with behavior at school.

The community school owns little physical and recreational equipment and the resources came through Johnson-O'Malley in title IV education funds. School administrators are naturally very reluctant to allow school property be used off school grounds or without the school's direct supervision.

Administrators are also prohibited by Federal regulations from allowing children over 14 years to use resources as these are not among the enrolled population of the school. These resources constitute all community property available in Supai for organized delinquency prevention activities.

The tribe lacks any specific facilities for juvenile detention. Children must be incarcerated either in the village jail or off the reservation, with all attendant problems of distance for both law enforcement officials and involved families. The tribal court, operated by the tribe under Public Law 93-638 contract, lacks staff training in family disputes under its jurisiction. But with no juvenile facilities for treatment, local ICWA workers provide only alternatives to off reservation counseling.

The tribe operates an alcohol family counseling program for inhouse services. However, this program provides direct services only to the adults.

The human development services, which is not funded anymore, also provides counseling to adults, but only to adults in regard to alcohol.

At the present there is coordination of the existing Bureau of Indian Affairs Branch Social Services Program. The tribes also coordinate services with the Indian Health Services, who visits Supai once a month.

Positive working relationships are developed with other community agency programs in order to prevent situations which result in family disruption or a crisis situation in the home.

The tribe continues, and proposes to enhance substantially, its juvenile delinquency and consequent family breakup preventive component.

About 14 children, as I said, and families have received services this year in regard to alcohol and drugs. We have expanded our own counseling program from 14 to 28 children. Also, in the area of alcohol and drugs.

All workers that work with kids in Supai are paraprofessional workers. The Supai Tribe is supportive of this fact because of the fact that the training is really needed in Supai in regard to the alcohol and drug abuse.

Also, the fact that title IV, where it states about the temporary placement of facilities for juveniles who are incarcerated, this is really a need in the village there, as I stated, because the children that are in incarcerated have to be taken out of the village and separated from families.

We wish that the children should stay on the reservation. At the present we place them in foster homes at the time that they are incarcerated, so they are not in the jail.

I think that sums up my statement. Though I did write a written statement, I will turn it in within 10 days.

Mr. **Richardson**. Without objection, your statement will be made a full part of the record.

You mentioned the specific problems of your people. I understand that in your area there is a lot of "Hollywood drug syndrome."

Is that accurate to say? The cocaine? There is a large penetration? Is that an accurate statement?

Ms. **Siyuja**. Not cocaine or LSD. Mostly marijuana. That is what they use in the village.

Mr. **Richardson**. Congressman McCain wanted me to ask a question before he left, and this question is, should our emphasis be on tribal control to tailor the programs to each area's unique needs?

Do you think the IHS should have more of role? Do you feel enough autonomy and input into the prevention process?

Ms. **Siyuja**. Right now the IHS does provide services for us, but also, I said, they only visit once a month. They come in maybe 1 or 2 days at a time, which is not enough time for any kind of workshops or training to provide for us.

Mr. **Richardson**. So you would favor more tribal control?

Ms. **Siyuja**. Yes.

Mr. **Richardson**. All right. Thank you very much, Bernadine. Say your last name for me.

Ms. **Siyuja**. Siyuja.

Mr. **Richardson**. That is exactly what I said.

Ms. **Siyuja**. You said, Siyuha.

Mr. **Richardson**. Thank you very much.

Ms. **Siyuja**. Thank you.

Our next witness is Ardell Ruiz, from the Gila River Indian community.

Ardell, we welcome you to this committee. I know I said "Reese" right? Didn't I?

Mr. **Ruiz**. Yes.

Mr. **Richardson**. Your statement will be inserted as part of the record. I understand you have a prepared statement?

Mr. **Ruiz**. Yes. I could say a partial statement. We would like to add more to it.

Mr. **Richardson**. You will summarize for purposes of the record.

[Prepared statement of Ardell Ruiz may be found in appendix III.]

STATEMENT OF ARDELL RUIZ, ACTING DIRECTOR, HUMAN RESOURCES DEPARTMENT, HEALTH BRANCH, GILA RIVER INDIAN COMMUNITY

Mr. **Ruiz**. Mr. Chairman, members of the committee, my name is Ardell Ruiz and I am acting director of the Gila River community Human and Resources Department, Health Branch. I am speaking in behalf of the Gila River community as the representative for Donald Anthony, Governor of the Gila River community. The Gila River community lies between the largest metropolitan areas of Arizona, and that is Tucson and Phoenix.

Interstate 10 divides the reservation. Because of the proximity of the dominant culture, the disadvantages as well as the advantages of modern life are available to members of the Gila River Indian community.

One of these disadvantages affects of modern life is the erosion of tradition of the Pima and the Maricopa Indians, and their values. This has resulted in the loss of cultural identity, the changing social conditions rendered to some of the people of Gila River, making it vulnerable to nonproductive behavior such as alcohol and drug abuse. In the Gila River community, the children are particularly affected by substance abuse.

They see substance abuse behavior modeled by significant adults and older siblings in their homes and in their community. Many young children are in homes without adequate supervision or attention.

There is the natural curiosity of the child to explore the environment and try whatever experiences are offered. All of these factors contribute to the use of alcohol, other drugs, inhalants by the youth of the Gila River community.

The tribal enrollment stands at 9,448 members. Young people under the age of 18 comprise approximately 42 percent of the population in our community. Surveys done within the community show most young people have tried alcohol by the age of 15.

Twelve percent of those surveyed admitted to the regular—have admitted to the regular drinking, once or twice a week. In addition to alcohol abuse many youth are involved in use and misuse of chemical substances.

Marijuana smoking in the middle schools in Saxton has increased in the 1983 to 1984 school year.

Law enforcement officials contact with youth is precipitated by drugs and alcohol in most cases. For example, 70 percent of the juveniles convicted of joyriding in the Gila River community and 45 percent of the chronic truancy violations are directly connected with alcohol or other drugs.

The community plans services reports that in excess of 80 percent of all traffic accidents involve alcohol. Further, they indicate that alcohol and substance abuse play an even larger role in assaults, homicides, suicides, and family violence.

As you can tell from what I have stated so far, the problem is one of epidemic proportions, and it is getting worse. Presently there are no programs significantly dealing with juvenile alcohol and drug abuse prevention on Gila River.

Our Alcohol and Drug Abuse Program employs one full-time staff to work in the area of prevention and education. He provides services throughout all seven districts that run just on this side of Coolidge, AZ, up to 19th Avenue, south of Phoenix, and also into the Oxton community, which is just southwest of our reservation.

The shear magnitude of the task, coupled with the diverse age group of the recipients requires a broad-brush approach to education. The unique and specific approaches which are affected with juveniles are oftentimes lost in the overall presentation.

In spite of the shrinking resources, our community maintains a system of coordination between tribal association services, health services, tribal courts, schools, and law enforcement. The Indian Health Services, and the Bureau of Indian Affairs, and off reservation programs, offer little hope in addressing the problem of juvenile substance abuse in our community.

Gila River community views the Indian Juvenile Alcohol and Drug Act, H.R. 1156, as a good beginning, but only a beginning. The $5 million being proposed could easily be spent in our community alone. The amount ultimately authorized must be realistic considering the overall code of H.R. 1156.

Our community also has concerns about the nature of the agreement between Indian Health Services and the Bureau of Indian Affairs as required in title I. Our fear is that this agreement will require Indian Health Services and the Bureau of Indian Affairs to incur significant administrative expense which when subtracted from the final authorization will leave little resources to impact the Indian juvenile drug and alcohol abuse problem.

The Gila River community will forward a position paper to the House Committee on Interior and Insular Affairs within the next 10 days. The report I have given is a brief summary of what we have proposed and are recommending.

Thank you.

Mr. Richardson. Mr. Ruiz, you were critical of the IHS and the BIA in terms of the potential overhead they would incur. In the hearings of New Mexico there were several witnesses who basically advised us, several tribes, that they want to bypass the BIA and IHS completely, that they would like to receive the funds directly, almost in the normal of complete tribal control. Do you favor that or not?

Mr. **Ruiz**. I think the way that we are set up here and the way other areas may be set up—and I think that is where we get back into the priorities—I think you can't place the same formula or methods in each area. At this point I think we have good working relationships with all the different people that are involved in providing services for Gila River.

Mr. **Richardson**. Well, you are a good politican. That was a good answer, good political answer. In New Mexico we don't have that, they just go straight out and say we want the funds directly, but I commend you.

I have no further statements and I don't think my colleague left one for you. So I thank you for your statement and we will expect that further statement.

I was reading your earlier version where you said you had some specific recommendations per title. I would like to see those.

I will look forward to reading your specific recommendations on the bureaucratic structure. I let you off the hook today, but I won't let you off the hook in writing.

Thank you very much, Mr. Ruiz.

Mr. **Ruiz**. Thank you.

Mr. **Richardson**. Our next witness is Mr. Edgar Walema, director of the Hualapai Tribal Council.

Your statement will be part of the record.

Do you have a prepared statement?

Mr. **Walema**. No, I don't.

Mr. **Richardson**. I would ask you to limit our statement to 5 minutes so we can get into some questions. If you can summarize, we would be most appreciatative.

Welcome, we look forward to your statement.

STATEMENT OF EDGAR WALEMA, CHAIRMAN, UALAPAI TRIBAL COUNCIL

Mr. **Walema**. I shall do that in less than 5 minutes, or whatever.

Mr. Chairman, and the hearing committee, I appreciate this opportunity to address an issue close to the hearts of Indian tribal leaders throughout the Indian County.

I am Edgar Walema, tribal chairman for the Hualapai Tribe. The Hualapai Tribal Reservation is located in the northwestern part of the State of Arizona.

We have approximately 1 million acres of land and we are isolated. The population of the tribe is approximately 1,300, with 800 to 900 living on the reservation. At the present I don't have a prepared statement, but within that prescribed time that the stats on your paper there, I will submit a prepared statement for the record.

Mr. **Richardson**. Do you support the bill?

Mr. **Walema**. Yes, I do.

Mr. **Richardson**. You are going to make it now?

Mr. **Walema**. I was going to make that.

Mr. **Richardson**. I am sorry. I apologize.

Mr. Walema. The bill that is in reference to is something that is very needed in the sense that we do have a lot of problems with juvenile drug and alcohol abuse. And the bill that has been referenced to would allow the tribal governments to utilize the fundings or utilize the material, or the organization that would give us that assistance in trying to combat the drug and alcohol abuse.

On my reservation, we are not faced with hardcore drug abuse. Heroin or any of those other hard substances. We are faced mostly with marijuana and alcohol abuse.

We had at one time in our tribal court a system that provided support in controlling this type of situation, but we don't have any funding available, so we had to phaseout that program.

And we had a juvenile removal initiative act from the State which assisted us, but that also went out for the funding. And small tribes such as ours don't have that type of funding to do things that we would like to do in wanting to control the drug and alcohol problems on the reservation. This is why H.R. 2624 and 1156 will be supported by the Hualapai Tribe.

Mr. Richardson. Thank you very much.

The question I have is one that I have asked several other witnesses, the emphasis on youth or families which seems to be emerging as one of the issues.

Do you have any views on that, whether the emphasis should be on the family rather than the youth or vice versa?

Mr. Walema. To combat drug and alcohol abuse, I think the family situation is where we should gear our emphasis toward. Indicating the family, and I think we can break that down to controlling the juvenile population.

Mr. Richardson. Thank you very much, for appearing before this committee. We look forward to receiving your testimony.

Mr. Walema. Thank you.

Mr. Richardson. Our next witness is Francisco Jose, vice chairman of the Papago Tribal Council.

I see that you have a statement for the record. I commend you for doing so. You have specific recommendations. They will be fully inserted in the record, and we look forward to your testimony.

[Prepared statement of the Papago Tribal Council may be found in appendix III.]

STATEMENT OF FRANCISCO JOSE, VICE CHARMAN, PAPAGO TRIBAL COUNCIL

Mr. Jose. Thank you, Congressman Richardson.

I would just like to make a brief summary of some or part of the testimony that we prepared.

You may not be aware, but our tribal membership is estimated at about 17,000 people, and we have a land base of approximately 3 million acres. And the acrege lies along the international border of Mexico and Arizona; which you can see is part of our problem.

Now, all we are asking from the tribal perspective is that in all principles, we agree with the law. However, for a more effective design we are just saying that we have an equal decisionmaking power, that we be involved from the bottom up, and that it is primarily what I am here to state today.

You asked a question—I believe Congressman McCain—is the emphasis on whether the family would be the area. With all due consideration, because we are limited by funding, that we go to the educational systems that we do have, that we again be involved in this, and that is primarily what I would like to say.

Mr. RICHARDSON. In that statement, you mean that we should emphasize the youth?

Mr. JOSE. Yes.

Mr. RICHARDSON. What is unique about your location that gives you added problems? The international border?

Are you talking about the increased traffic problem?

Mr. JOSE. Yes, that is it.

Mr. RICHARDSON. What other problems would you have being contiguous with the Mexican border.

Mr. JOSE. Alcohol. And mostly in the drug situation is the marijuana a question.

Mr. RICHARDSON. So you are problem is more acute, obviously, than most tribes.

Mr. JOSE. Yes, it is.

Mr. RICHARDSON. What is your view about—you mentioned decisionmaking.

What if I asked you the same questions I asked Mr. Reese, would you be able to answer the issue of direct funding to you? How would you feel about that?

Mr. JOSE. You must be talking about the government to government situation.

Mr. RICHARDSON. That is correct. In other words, giving the IHS and BIA less of a role, or somehow streamlining the bureaucratic diminution of the problem.

Mr. JOSE. I think that would be a possibility in the future. However, there has to be a lot of discussion that would go into it, particularly because, again in the past, because of the limited funding, is the training areas or management areas of such a situation only limits the tribe, at this point in time.

If you were to address the amount of funding to increase our management capabilities or our training capabilities to individual tribal members, gaining the expertise to deal with the situation, then that is a possibility.

Mr. RICHARDSON. Tell me some of the programs on your reservation that in your judgement would work, that perhaps haven't been tried? Some witnesses mentioned a combination of halfway houses with work-study programs where they are working and learning a trade at the same time they are getting treatment.

There are a number of innovative programs that have come to our attention. Are there any in your area that might be useful for this committee to pursue?

Mr. JOSE. I think as such we have made a number of attempts to address this question or to find some solutions, but I think because of the logistics, as I mentioned, the 3 million acres, it is hard for our service to deliver, to even come up with any kind of ideas how to address that question areawide.

Mr. RICHARDSON. Now, you have a prepared statement that is to be inserted in the record, and I commend you for it. I think you are supportive of most sections.

Thank you very much, Mr. Vice Chairman.

Mr. **Jose**. I would like to just add; we appreciate all the work you and Congressman McCain put into it.

Mr. **Jose**. Thank you very much.

Mr. **Richardson**. Our next witness is Ms. Mike Smith. Where is Ms. Mike Smith?

Ms. Mike Smith is representing the Pascua Yaqui Tribe.

Can I call you Mike?

Ms. **Smith**. Sure, please.

Mr. **Richardson**. Is that correct?

Ms. **Smith**. It is Michael.

Mr. **Richardson**. What is your name?

Ms. **Smith**. Michael.

Mr. **Richardson**. Would you identify who is accompanying you, please, for the record?

[Prepared statement of the Pascua Yaqui Tribe, with attachments, may be found in appendix III.]

PANEL CONSISTING OF MICHAEL SMITH, HEALTH DIRECTOR, PASCUA TRIBE; JUDGE HARVEY; AND PEDRO FLORES

Ms. **Smith**. First I would say good morning, Mr. Chairman, and staff. My name is Michael Smith, believe it or not. I am the health director for the Pascua Yaqui Tribe.

And with me today are Judge Harvey and Pedro Flores, to my right. He is in charge right now of our youth activities program.

Mr. **Richardson**. What is the judge, what circuit?

Ms. **Smith**. He is our tribal judge.

In the audience, I might add, other tribal staff have come to support us.

Mr. **Richardson**. Will you recognize them?

Ms. **Smith**. Would you mind standing.

Mr. **Richardson**. Please give your names for the record. You have to give your name for the record, the stenographic reporter doesn't have a TV camera.

Ms. **Smith**. Robert Valencia, director of Johnson-O'Malley; Tina Pena, with the administration office; Lydia Goudeau, who is our pregnancy counselor; Suzie Francisco, with our tribal court; and on the left we have Vincenta Munoz, our director of nursing; and with her her husband, Francisco Munoz, who is with one of the treatment centers that are providing services for the Stratford Center, an outside service we have been utilizing.

Mr. **Richardson**. Thank you very much.

It makes it look like the hearing is crowded anyway. So thank you anyway.

Please proceed.

Ms. **Smith**. I have a written document which represents the testimony of the Pascua Yaqui Tribe in more detail. I would like to enter into the record at this time a summary of the position of the Pascua Yacqui Tribe regarding the Indian Juvenile Alcoholism and Drug Abuse Prevention Act.

Mr. **Richardson**. It is therefore submitted for the record.

Mr. **Richardson**. You are going to summarize your statement?

Ms. **Smith**. Yes.

Under title I, under the interdepartmental agreement, we support the provisions of Title I, providing for coordination of BIA and IHS programs and the identification of available resources and to reinforce implementation with a maximum tribal participation.

Under title II, we support the provisions of title II. We would like to see added assistance in gaining better access to the public school system, with the provision of special training for counselors and school staff in the area of drug and alcohol, and we would like these to be tribal specific, which they aren't right now.

Mr. **Richardson**. What do you mean tribal specific?

Ms. **Smith**. We are in a public school system, we have no reservation schools, so many of the staff aren't really aware of the tribal problems with the youth.

We would like to see more active support and participation of BIA in easing contractual arrangements, to provide more flexibility in providing comprehensive summer programs to the youth. Under title III, Family Services, the Pascua Yaqui Tribe has a concern in the area of training.

The tribe feels any training provided under provisions of title III must be tailored to meet specific tribal and logistic needs. Traditionally, training has been provided by BIA or IHS on a national level, and we feel it would be more relevant if addressed and provided on a local level.

Since many areas have resources or trainers nearby with programs to fit the needs of the specific region or area, we feel it should be utilized.

Under title IV, Law Enforcement, we support the ideas, and recognize the need, for an active role by law enforcement. However, again because of the logistics, and the great variance of tribal specific needs, we feel as the title is currently stated, it is a little restrictive because it sort of emphasizes immediate placement into facilities, and we feel maybe the tribes should be more involved in identifying what should be done with the tribe before they are authomatically placed somewhere.

Mr. **Richardson**. I thought the tribe does have a role?

Ms. **Smith**. Well, we do, but maybe not to the extent that we would like. I mean we do. But when we are talking about our BIA police force—and the judge, I think, will comment later—sometimes they identify——

Mr. **Richardson**. Why don't you do that now, Judge? This is an important point we don't want to miss.

Mr. **Harvey**. As Mike has stated, we do have limited resources and it has been a major problem because of cutbacks also. As far as the juveniles, we have to incarcerate our juveniles 156 miles away from the reservation. We are incarcerating them.

As far as placement on the reservation itself, we currently do not have any placements whatsoever, so—what we do have, we have foster care homes off the reservation. It also creates a lot of problems for the police department.

Realizing our tribal court system has only been in implementation for 2 years, when we first started out the first year we were only on a 20-hour basis, and right now we just got word as of Friday, we are going to go back to 20-hour basis again.

So, we don't have any type of programs that could try to alleviate any of these problems. It seems like the problems are getting worse as we are getting along because of cutbacks.

So, it is everything in detail as far as what Mike is saying here. It is just really limited in everything.

Mr. **Richardson**. I wasn't aware also—counsel is telling me your tribe was give status in the last Congress.

Mr. **Harvey**. In 1978, to be exact. The Federal program—from this year, it has been 2 years various programs have been implemented.

Mr. **Richardson**. You have no problems with this bill superseding any kind of tribal jurisdiction?

In your testimony or Mike's—can I call you Mike?

Ms. **Smith**. Please.

Mr. **Richardson**. In Mike's testimony, it is referred to.

What did you do with the testimony, Frank? Did you take it away from me?

> The tribal court system is now in the process of developing an interjurisdictional agreement to provide courtesy jurisdiction for children committing offenses off reservation. With the number of referrals from all sources that the child welfare worker, and justice system are receiving, there is not adequate staff.

So it is a staff problem?

Mr. **Harvey**. Right.

Mr. **Richardson**. Go ahead, Mike. You had better finish this testimony .

Ms. **Smith**. I don't want to run too long here.

Let's go to title V. As stated in unmet needs for the Pascua Yaqui Tribe, the only facility for detention of juveniles is Gila River. As I said, 130 miles away. It might be closer to 156 miles, one way.

We feel the issue of detention or rehabilitaion facilities is necessary since with strong emphasis on prevention, there will still be youth in need of care and treatment.

So, I think it needs to be recognized. Then under title VI, we feel that—and this isn't just crying for more money, we do feel the appropriation that was recommended may be low.

And then I would like to say, we don't like to come across negatively, because we do have a real good youth activities program, and real tight interdepartmental cooperation. All the departments working with the youth are trying to pull together.

But in the systems coordination, one of the problems we find is that the way the funding is handed down to the tribes—and I address that a little in detail—it causes an awful lot of fragmentation, because it is seen as BIA money or IHS money. With our summer programs, those two don't seem to really talk and cross over.

The tribal level tries to talk and integrate the dollars, but on a higher level, we are having a bit of difficulty with trying to use those dollars to give us a full circle of a programs, rather than we will treat this piece of the child under drugs and alcohol and this piece under mental health. We feel that the total child and all their problems as one, should be treated.

So I think that is one of our problems with the coordination, and maybe better communication.

Mr. **Richardson**. Thank you very much.

Counsel Ducheneaux has asked to ask you a question.

Mr. Ducheneaux is the majority counsel for the committee.

I will extend the same courtesy to minority counsel from the majority.

Mr. **Ducheneaux**. You mentioned in your statement these things ought to be tribal specific, particularly with respect to Pascua Yaqui where there are no BIA schools and the children attend public schools.

When the legislation was being drafted, there was some problem figuring out a way to insure that the educational programs for prevention in the schools could be put into the public schools, but there was concern that if you did it just for the Indian children in the public schools, they might be subject to ridicule and embarrassment by the non-Indian fellow school students because they would be singled out for drug and alcohol abuse educational programs and the others would not.

How can the bill perhaps be changed to insure that the Indian students in public schools can get the benefit of this education without causing that kind of problem?

Ms. **Smith**. I think maybe that would be better addressed—and I am not sure that I am prepared to answer that off the cuff, because the Johnson O'Malley director maybe could more specifically address that in actually working with the youths.

I think the reasons we stated it in the manner that we did, and as I shared with you, that in the schools that our children attend, we are nine—three elementaries, three junior highs, and three high schools—of the total Indian enrollment in those schools, 2,000 some children, 58 percent—and last year even it was 17 percent of those children happen to be Yaqui children.

So we felt that in our case, anyway, the high concentration maybe did require a little bit more specific—Yaqui specific—because we see our kids being handled basically by standards that might apply to maybe even other tribes but not specifically to our kids.

Mr. **Houtz**. Pascua has no BIA school or contractual school. There is a portion in H.R. 1156 that states that the Secretary of the Interior shall keep the BIA schools and contract schools to open in the summer.

Would it be better for us to change the legislation, whatever comes out of committee, to have the Secretary work with the tribe to develop summer programs regardless of where they are situated, whether in public schools, on reservations, tribal programs? I was thinking you had your summer program director here. Maybe he could make some comments.

Ms. **Smith**. Let me make one statement.

That is where we made the contractual arrangement with BIA. We ran into a bit of a problem with using one of the public schools with a BIA contract, and because of some of the contractual arrangements between the two entities, we ran into problems.

Also, I think that we should also recognize tribal facilities that might be—in our case, our summer program. And I will let Pete address that more.

Mr. Flores. We did have a problem like that summer program we are trying to get going with the recreation during the summer, and because of the different facilities of funding, we were unable to get a summer program which we were considering under a nutrition part of the program.

But we do have similar problems throughout the community of utilizing outside facilites because a lot of people assume just because we are a reservation, we have facilities there on the reservation already, when, in fact, we don't, so we try to utilize the outside facilities. And that is where we come into the problem. A lot of people say, don't you live on a reservation?

Well, we do, but we just got started 5 years ago. We do not have all the facilities that a lot of people think we do have on reservations, which makes it hard in trying to build something, and a lot of people assume you have that on the reservation also.

When we try to utilize outside facilites, it is not possible.

Mr. Richardson. Judge, would you like to add anything further?

Mr. Harvey. I wanted to add, 2 years ago the number of juvenile delinquency has really taken a sharp increase——

Mr. Richardson. Speak up. I see some people straining in the back.

Mr. Harvey. The juvenile delinquency activities have sort of—well, they have increased doubly. When I first arrived there were about 34 cases throughout 1984. The whole juvenile—as far as children's court is concerned now, that whole amount has doubled.

There are going to be also additional homes becoming available later on. There are just no facilities. We do not have a detention center, nor do we have any type of residential home on the reservation.

Those are the types of facilities we need right now. It is causing a lot of problems for our juveniles at this time.

That is the only thing I wanted to add.

Mr. Richardson. It has been very good testimony you all have presented.

Is there anything further you wish to leave for the record of this committee?

Mike?

Ms. Smith. I would like the reinforcement. The judge said he doesn't know how reservations go, but when I started with the tribe in the health department 5 years ago, there were approximately 400 people residing on the reservation.

There are 1,010 right now; and by 1987 we will have 3,040 people residing on the reservation with the housing. So all—I think the increase in our juvenile problems is because we have people coming in from other communities, some of our farming communities. And to have to integrate kids from all these different areas, one of our areas, which is hard-core urban, a lot of heroin problems are coming on to the reservation that weren't there before.

I think we are seeing a growth pattern back to the reservation, and it is presenting a few problems we are not yet fully staffed and able to handle. Outside resources think if a program exists on the reservation it becomes our responsibility. They don't always look to see if we are adequatly staffed or funded to handle them.

Mr. RICHARDSON. I am sure with people like you, they really are. So thank you very much, the three of you. We appreciate your appearing before this committee. We are moving right along, and we have got two more witnesses. Normally the committee has a break.

What I will do, in the interest of giving everybody an opportunity to say something, after the prepared statements of all witnesses, and some of my committees, and since I can overrule all my other colleagues here, I will allow for a 1-minute statement by any member of the audience at the conclusion of the hearings, any statement any of you would like to make.

So if you would like to think about that, we will allow that.

Elton Yellowfish, Salt River Pima-Maricopa Indian community.

Welcome to this committee. I have in front of me your prepared statement. It will be inserted in the record. Please proceed.

[Prepared statement of Elton Yellowfish may be found in appendix III.]

STATEMENT OF ELTON YELLOWFISH, HEALTH PLANNER, SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY

Mr. YELLOWFISH. Thank you.

I am Elton Yellowfish. I am the tribal health planner. At this point I represent the Salt River Pima-Maricopa River community. We are located adjacent to Phoenix, Scottsdale, east of here, and north of Mesa.

That is good and that is bad. It is good in respect that our tribal people have access to, 5 minutes away from 117 stores and shopping centers. It is bad because it allows an easy flow of drugs and alcohol.

The Salt River Indian Reservation encompasses about 25,000 acres of land, the vast majority agricultural. In 1984, our tribal population was 4,075. In 1983, our last survey indicated 50 percent of our population that was below 18½ years of age.

Based on these statistics alone, Salt River development has a concern about its young people. I wanted to comment at this point on some of the items within the Indian Juvenile Alcohol and Drug Prevention Act. We try to look at these in priority as we see them at Salt River.

Obviously, the most important thing is the money, the appropriations. Funding of $5 million appropriated apparently, we see this as not being sufficient in light of the fact this is going to be addressing a problem that has progressed over a period of time, a period of years.

Young people, alcohol, and drugs has been overlooked. It has just not been there; $5 million, we see it is not going to be sufficient to do this. We see some problems in coordination of the bills.

Programmaticwise it can work, the two programs. An example of this is our staff people at Salt River, tribal people who are salaried through contract from Indian health, salaried people on the tribal level contracted, paid by the Bureau of Indian Affairs, work hand and hand to provide services for our clients, our young people. That works at that level.

But we have some very big questions on how this is going to work when the joint bureaucratic agencies get together for the purpose of working with this particular piece of legislation. We certainly agree with the training part for tribal employees, we think we should give a priority over. If we are going to to work 100 percent with our young people, this needs to be in order.

Law enforcement. Juveniles who are apprehended must be protected at all costs. Not all youngsters need incarceration. Consideration must be given for parental involvement at some point. Development of some sort of emergency language must be incorporated into this particular law.

Salt River agrees with the intent of this legislation 100 percent. We want to see the bill passed. We recommend it be passed because of two basic reasons.

First of all, it will provide Salt River for opportunity with initial funding from program startup. At this point we have no structured program for our young people to deal with drug related, alcohol related problems.

We do have programs dealing with adults with alcohol. We do have programs dealing with young people at our youth home who are referrred through our tribal courts, through our police, and through our social services department, but no structured program exists as such for the young people.

Salt River needs this type of law as a reinforcement as we experience daily requests of seeking funding. That is the name of the game, seeking funding to provide programs and services for young people. This is a tool we need very much.

The level of funding, I notice you made a sign, a rather relief sign, perhaps, of some sort, when Mr. McCain indicated his recommendations of $30 million this morning. And sometimes this is a message that the Indian people get from people in Congress; $30 million to do an Indian youth program?

Well, we take it very seriously. For Salt River, we want to recommend $20 million, perhaps not quite as high, but the problem is very serious. We would like to see this kind of appropriation available to do these kinds of programs.

I have included a number of attachments with our proposed statement that reflects some statistical numbers for our young people at Salt River.

At this point his concludes my remarks.

[EDITOR'S NOTE.—The above-mentioned attachments may be found in appendix III following Mr. Yellowfish's prepared statement. See table of contents for page number.]

Mr. RICHARDSON. I want to commend you for a very good statement, and I am going to once again ask my counsel if they have any questions.

Mr. DUCHENEAUX. I have one.

You mentioned the issue of funding, and earlier other witnesses mentioned they were concerned that overhead funds would take away a lot from specific programs. Yet I stll don't have a witness from your State of Arizona that will give me recommendations as to how we can streamline the bureaucracy and still provide services more efficiently.

Are you prepared to give me some recommendations on this issue? That perhaps would accomplish your goal of spending more for treatment and servies and less overhead?

Mr. **Yellowfish**. Well, it seems if we are talking about more money going in for direct services, let's do it directly with the tribe, Federal Government and the tribal government. Therefore, we would bypass the bureaucracy and the Bureau of Indian Affairs. It is that simple.

Mr. **Richardson**. I commend you on your view, and you are the first person that has made that recommendation. I commend you for it.

Thank you very much, Mr. Yellowfish.

Mr. **Yellowfish**. Thank you.

Mr. **Richardson**. Our next witness is Ms. Kay A. Lewis, juvenile judge, White Mountain Apache Tribe. Judge, welcome to this committee.

Is that correct, Judge—I want to be sure for the record—Kay?

Ms. **Lewis**. Yes.

Mr. **Richardson**. Please proceed, Judge.

[Prepared statement of Kay A. Lewis may be found in appendix III.]

STATEMENT OF KAY A. LEWIS, JUVENILE JUDGE, WHITE MOUNTAIN APACHE TRIBE

Ms. **Lewis**. I would like to add to my statement that I do support this bill. Also, the questions was asked also about whether funding should be directed to the tribe. Speaking for my tribe, it should be directed to the tribe.

Mr. **Richardson**. So that is two of you, two brave souls in Arizona?

Ms. **Lewis**. I am not a very good politician, I guess.

Please permit me to introduce myself. My name is Kay Anthony Lewis, juvenile judge for the White Mountain Apache Tribal Juvenile Court, White River, AZ. I am very happy to be here with you today. Thank you for allowing me to come.

When I started to prepare my speech and to do some homework about the Federal Government improving the life of Indians youth, I began to feel overwhelmed because of the unique relationship between an Indian tribe and the Federal Government. The Government seems to be involved in so much of the education, social services delivery that impacts on the Indian youth.

The Federal Government must continue to commend itself to provide not just dollars but sense. I mean the sense of hearing so they listen to the Indian tribe and find out what is needed to be improved on the reservation.

I realize that I have been invited because of my interest and concern about increasingly one of the greatest killers that confront Indian youth, that is alcohol and drug abuse. Before such abuse can be effectively decreased we need to obtain more funds for alcohol and drug abuse prevention to eliminate all of the bad or weak points.

For years effort to curb alcohol and drug abuse by law enforcement alone have failed. Better training and appropriate outlook are necessary. The Federal Government must become involved in the resolution of the problem on the reservation in the treatment process for Indian youth.

One of the most critical problems in trying to bring about changes in respect to Indian youth on the reservation is the inability to develop such a far-ranging treatment program due to tribe financial resources are extremely limited.

An alcohol and drug abuse prevention treatment program is needed in the future to help keep Indian youth on the reservation, strive to overcome their problem, adjust to the reality of life, protecting them and keeping them from becoming criminals as an adult, and rehabilitating them.

I want to thank you for inviting me to speak, to share with you my conviction concerning the needs of Indian youth. I have been on order, and I hope that in some small way progress will be achieved to reaffirm our commitment to protect Indian youth, and we must be prepared.

I want to thank you.

Mr. **Richardson**. Thank you very much, Judge. Have you had a chance to look at the temporary emergency shelters? Are you supportive of that concept?

Ms. **Lewis**. Yes, I am.

Mr. **Richardson**. You concur that is a sound approach?

Ms. **Lewis**. Yes. On the reservation. I am not speaking for all tribes here.

Mr. **Richardson**. Yes. Thank you very much, Judge. I appreciate your testimony.

Now, what we will move into is—are there any public citizens that are out in the audience that would like to make a statement for the record?

We have a request here from the chairman of this committee that Ms. Jo Ann Crissy, from the Papago Peer Council, will make a statement, and Francisco Jose will be accompanying her up.

Didn't we just see Francisco Jose?

So he is back for another encore.

Ms. Crissy, welcome to this committee. Your statement will be submitted for the record.

Mr. Jose, do you have another statement?

Mr. **Jose**. I just want to address the comment you made.

Mr. **Richardson**. Thank you.

Please proceed.

[Prepared statement of the Papago Peer Counseling Group may be found in appendix III.]

STATEMENT OF JO ANNE CRISSY, PAPAGO PEER COUNCIL

Ms. **Crissy**. I want to thank you for being here. I had hoped to bring several students with me——

Mr. **Richardson**. Where are they? That is the only reason I came to this hearing, to see your students.

Ms. **Crissy**. They have been at a weeklong alcohol and drug abuse prevention workshop in Prescott, all week getting their testimony ready and working with other students in the State. Basically, I am sure they are all asleep right now. I didn't have the money for transportation costs to——

Mr. **Richardson**. Francisco Jose would have taken care of the problem.

Ms. **Crissy**. They would like to enter their written testimony at a later time, and they asked me to come, and I am reading from their little notes that we were doing in the van last night at 12 o'clock when they realized they weren't going to participate.

The peer counseling group wishes to enter testimony as to the needs for financial resources to aid them in their efforts to save their peers lives. The peer counseling group has realized that as a people they are afraid of genocide.

They feel due to the psychological and physical long-term effects of alcohol and drug abuse on the reservation, it is a great problem on the reservation, there is a need for it to be recognized as a health problem. They are really frightened that alcohol and drug abuse has become synonymous about growing up on a reservation, and they want to start and have moneys to start prevention programs.

They have learned the way is to do this, and need the resources to be able to do this. Peer counseling has been found to be one of the most effective ways to prevent alcohol and drug abuse.

And, as I said, the kids want to set up a SADD Program, Students Against Drunk Driving.

On an Indian reservation it is difficult—it is easy where you have transportation, it is not easy on a reservation. They will need money for resources to do that. We work right in the schools. We work with the little kids.

There are centers for the elementary schools, junior high, and high schools. Their objective is to train peer counselors and to work with the tribe to set up activities for students in the prevention effort.

So their testimony will be along the lines of the needs of children of the Papago Tribe.

Mr. **Richardson**. Are you a psychologist?

Ms. **Crissy**. No; I am not.

Mr. **Richardson**. Psychiatrist?

Ms. **Crissy**. I have been called of things.

Mr. **Richardson**. You are a peer counselor; and yesterday in New Mexico there was a witness that stated that there was a greater need to offer psychiatric services at that time the very earlier younger level to some of the kids as part of the treatment. Enough is not being done, and emphasized by IHS and by any of the substance abuse programs to include psychiatric treatment, that there was too much reliance on peer pressure and other methodologies.

Do you agree with that?

Ms. **Crissy**. I feel there is a need for psychiatric counseling in Indian health care. I don't know whether that is being covered enough. I don't think that is an issue at this point. I think that both can help. And when we are talking prevention we need both.

Mr. **Richardson**. You are on the firing line with many of these kids, and you see them, and you deal with them. Could you give us a synopsis of, I guess, two very easy questions.

One, why do they turn to drugs and alcohol? And, B, what have you found is the most effective way to get them off that hook?

Can you in a nutshell give a philosophical or specific answer to those very easy questions?

Ms. **Crissy**. Philosophical versus specific, I think those are two different answers.

Do you want the specific?

Mr. **Richardson**. Both. If you have answered those questions there is no need for us to go——

Ms. **Crissy**. OK.

The most effective way as an educator—I am a teacher—that I have found, and that I have worked effectively with—and I have just returned as a facilitator from a workshop where we trained 200 students in the State of Arizona to go and be a school-based prevention advocates, and we have been very successful.

One of the most effective ways is though activities and to touch on the peer pressure. You can stay straight if your peers are bugging you to stay straight. And if it comes within a school environment where it is not cool or whatever to be addicted to be using or abusing drugs or alcohol or inhalents, then that is another trend that is set.

MADD and SADD, Students Against Drug Driving, statistics show it is effective.

Mr. **Richardson**. That it is effective?

Ms. **Crissy**. That it is effective. SADD has gone into schools and dropped drug abuse substantially because they have changed the mode. It is no longer cool, it is no longer what your peers want you to do. That is the only way. Anything that we say is not cool, what the kids say is cool.

Mr. **Richardson**. You tell the kids they disappointed at least one Member of Congress for not showing up.

Ms. **Crissy**. A couple of them were disappointed. They were disappointed.

Mr. **Richardson**. Sorry about that. You certainly have represented them well.

Do you want to say something, Mr. Jose?

Mr. **Jose**. Yes.

There was a question you had asked about the government-to-government relationship, and there is a possibility that—for instance, the Papago Tribe strongly believes in this concept, and also that there is that possibiliy that something like CDBG might be appropirate for the more directional allocation, and the fiscal responsibility to the tribe.

Mr. **Richardson**. That would be take care of the problem for you, if you were eligible for that?

Is that what you are saying?

Mr. **Jose**. That would address more of the problem. I wouldn't say it would take care of the problem totally.

Mr. **Richardson**. OK.

Ms. **Crissy**. May I add one thing?

Papago Peer Council is geared toward cultural awareness and positive self-esteem through cultural methods, and the kids research their traditional ties to help their peers and themselves to stay free from drugs, because they don't mix.

Mr. **Richardson**. When you do peer counseling, do you have the parents too?

Ms. **Crissy**. As much as possible. We are talking about codependent children a lot of times, too, which means there are students whose parents are alcoholics.

Mr. **Richardson**. So, you would endorse what several other witnesses said, that we need to make this bill more family oriented rather than just strictly youth?

Ms. **Crissy**. I think the bill should be targeted towards the family, which I think is a strong possibility. When you are dealing with codependententы, chemically dependent families, it is an ideal way. They can survive with the parents alcoholism or drug abuse, and they can also help, and they are the key to help, having the parents listen.

The SADD Program as an example, my students are working on a parent-child contract which would be a contract between the kid. If the kid did use drugs, he would be contacted to get home safely. In the contract it also says if none of them is a positive role model, they will not use drugs around the kids.

It is a positive step in the right direction.

Mr. **Richardson**. Thank you, Ms. Crissy.

Thank you, Mr. Jose.

I guess the Federal panel has arrived.

Dr. Ted Redding, Chief Medical Officer of the IHS, with Dr. McCoy, and Dr. Burns, and the BIA people, Mr. Jim Stevens, accompanied by Mr. Pete Sota, State Area Director, Office of Education, BIA.

These folks have been here all the time.

Mr. **Richardson**. Why don't you all join this panel. You are all the official representatives of the U.S. Government.

Mr. **Stevens**. It may be one of the few times we have gotten all together.

Mr. **Richardson**. For purposes of the recording of this committee, I am going to ask, I guess, Dr. Redding—where is Dr. Redding?

Will you introduce the members of the panel for the purpose of the recording and the proceedings of the hearings?

Mr. **Redding**. Dr. Thomas Burns, is the Chief of the Alcoholism Program for the Phoenix area. This is Dr. McCoy, Chief of the Mental Health Branch.

Mr. **Richardson**. He is on your right.

Mr. **Redding**. Mr. Pete Sota, and Jim Stevens.

Mr. **Richardson**. Which is Pete Sota?

Mr. **Stevens**. I am Area Director for——

Mr. **Richardson**. You cover Arizona and what else?

Mr. **Stevens**. Nevada, Utah, and we go into several other States.

Mr. **Richardson**. You don't go into New Mexico?

Mr. **Stevens**. No.

Mr. **Richardson**. Who is going to be first?

We have prepared statements that will be inserted in the record. It would be helpful if you summarized, but also let me just say one thing.

I commend you for coming to this hearing and staying and listening to all the witnesses.

I didn't know if you were here because you figured I would move faster or slower. It is important you have listened to many people who have given their input.

If at this time you feel you would like to refer to any statements made earlier, like what Miss Crissy said or what Francisco Jose, or some of the other witnesses have said earlier, please feel free to do that. If we can have that kind of input, it would be very useful.

I will ask you to proceed.

[Prepared statement of Jim Stevens may be found in appendix III.]

PANEL CONSISTING OF TED REDDING, CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE, ACCOMPANIED BY DR. GEORGE McCOY, CHIEF, MENTAL HEALTH BOARD AND THOMAS BURNS, PHOENIX, AZ OFFICE; AND JIM STEVENS, AREA DIRECTOR, PHOENIX AREA OFFICE, BUREAU OF INDIAN AFFAIRS, ACCOMPANIED BY PETE SOTA, STATE AREA DIRECTOR, OFFICE OF EDUCATION

Mr. REDDING. Mr. Chairman, and staff members, I appreciate the opportunity——

Mr. RICHARDSON. Talk into the mike.

Mr. REDDING. In reference to what has been said previously, some of the questions have been answered as far as the funding mechanism.

As far as time is concerned, I think the important factor is the fact that all three groups cooperate, and I really—from the Indian health perspective—I am not hung up on how the money gets there as long as the results are obtained. It does need cooperation between the three independent groups.

Basically to summarize the Indian health position, in 1978, the alcohol and drug abuse programs were transferred to the Indian Health Services, and for the next 5 years or so in the Phoenix area the protocol for running these programs stayed about the same. That was basically that there was a relationship between the Phoenix area office and the tribal programs, and that was about.

It was kept separate to a good extent in the clinical programs of the Indian Health Services. In 1983, the Phoenix area, attempting to generate a little more cooperation at the servicing level, transferred the management of the technical assistance responsibility for the various tribal contracts to the service unit directors and representatives of the service unit.

We feel this has had its problems, but overall I believe it has resulted in more involvement with the clinical staffs in the preventive, and entire preventive aspects of treatment of substance abuse.

Generally speaking, however, our doctors and nurses are trained in stopping and treating infections, and they are not well trained in the preventive aspects of any area in medicine. It is because of that fact that we find ourselves in somewhat of a dilemma as far as funding for specific preventive programs.

If we differentiate resources from the hospital and ambulatory care segment of our program into the preventive aspects of alcoholism. We find that the resources just do not stretch far enough. And generally speaking we feel that that would inappropriately downgrade the level of care, the ambulatory care setting and hospital setting, to an unacceptable level.

We have a couple innovative programs in the Phoenix area I feel. One of the most exciting to me is a cooperative approach with the BIA of the Sherman Indian School where we have initiated, and has been in effect for about 1 year, the start up of that program.

It is gaining momentum this year, and this fall season, when the students come back to Sherman and, well—be I hope in full bloom. That program alone is costing the Indian Health Service over $300,000 on an annualized basis.

We don't have that kind of money to put everywhere. We are trying a innovative program that does relate to getting to the students when they are in a more malleable state, and we hope then to be able to expand it somewhat to the other areas, into the private school sector, as well as, the Indian School Program.

Mr. RICHARDSON. Thank you. Who is going to be next?

Mr. STEVENS. Mr. Chairman, my name is Jim Stevens, and on my left is Pete Sota, who is the Phoenix area program administrator.

I have been directed to stick pretty close, but I would like to summarize it.

It takes 10 minutes to read. It is a little long.

The Bureau of Indian Affairs serves 47 reservations in 3 States, where we have the jurisdiction. We, of course, don't represent the Navajo Nation. The Indian population on the Indian reservations is approximately 118,000. One-third of these people are children under 16 years of age.

We separated our presentation into several different areas. The first area is education.

The Indian Health Service made a study at Sherman High School, and they found there was an average of 130 behavorial incidents each month. The No. 1 infraction was alcohol abuse. They began a cooperative effort in March of 1984, and developed a project which is entitled: "To Your Health, Living with Alcohol."

We are now in the process of evaluating the success of this program. Communication has developed quite a bit between BIA and the staff of the Indian Health Service, and there are a number of programs in the schools throughout the area.

In law enforcement, there are no special detention facilities in the Phoenix area specifically for juveniles arrested for alcohol and drug related crimes. Many adult facilities are used to house juveniles, but in separate areas.

Some of these facilities do not have complete sound and sight separation between the adult and juvenile inmates. We are in the process of renovating our facilities so that we can take care of that requirement.

Two reservations have detention facilities exclusively for juveniles. Access to State facilities have been, for the most part, on a case by case basis. Nevada and Arizona have denied custody of juvenile youth adjudicated through tribal courts.

In the juvenile services area, we spent a couple days calling the courts around the area because of the figures that we ran into here. We had in calendar year 1984, 1,400 juvenile cases went through tribal courts, and—among alcohol and drug realted offenses—and this was 30 percent of the total cases handled by courts.

We have what amounts to a disclaimer immediately following, and there is even additional reasons beyond that.

The juvenile cases we encountered, included custody cases, child abuse cases, where there would be no question as to whether the child will be on alcohol or substance abuse or not.

It has been my experience that when you are talking about trouble on Indian reservations, you are talking about substance abuse in a great majority of the cases, and I would say something in the neighborhood of 75 percent.

Some tribal courts have juvenile probation officers and counseling staffs, but most professional court staff service adult offenders. No probation or counseling staff is provided to an BIA court of Indian offenses.

And I am sure you are aware that the BIA actually runs the court.

In social services, almost all of our services are contracted throughout the area. We provide residential care to some 34 youth, whose problems are identified in part as substance abuse. As young people are entering and leaving these programs in a year's period, we service about twice this number.

For the past 2 years there have been no placements made where Indian Health Service shared the cost of care. In most cases where the BIA Social Service Welfare Program provides cost of placement services for youth with related substance abuse problems, the primary reason for placement is not alcoholism or drug abuse.

Examples would be maladapted behavior, such as delinquency, negative family relationships, and other serious interpersonal relationship problems.

Family and group counseling service are provided by Indian child welfare grant workers and BIA social workers. Half of the 24 Indian Child Welfare Act grantees in this area attempt to reach parents by providing parent effectiveness training, and this includes alcohol and drug abuse topics.

Youth group counseling sessions are also held to assist in achieving independence of problem solving, and again this is by this same group of people.

This concludes my statement.

I would be happy to answer any questions you might have.

Mr. **Richardson**. Thank you. I would like to ask you, Mr. Stevens, and the other witnesses—I guess my first question is, Do you support the enactment of H.R. 1156, and H.R. 2624?

It would be the IHS first and then BIA.

Mr. **Stevens**. Our organization hasn't taken a position on the bill yet. Obviously it fills some needs. That is something that will have to be answered by the central office.

Mr. **Richardson**. What about the IHS?

Mr. **Redding**. We certainly support the intent of the improved preventive efforts in the field of drug abuse and alcoholism.

Again as far as an official Indian Health Service statement, I am not in a position to make that. We support the intent of the legislation, yes.

Mr. **Richardson**. I am glad to hear you say that. On page 2, of your statement, you comment in Arizona and Nevada, two attorney generals are denying custody of Indian youths adjudicated through tribal courts.

Now, what is the impact of decisions like this? Doesn't it kind of put a damper on any kind of law enforcement scope that we could make out of this bill?

Mr. **Stevens**. Yes, sir. Nevada and Arizona have a facility called Dolby Mountain that handles the hardcore problems. And, very frankly, when you are into a problem like this there are going to be a small percentage, and something is in the neighborhood of 5 percent.

You really need a very highly structured and very controlled environment. We don't have access to that type of environment.

The kids that fit this type of a situation usually end up sitting in a cell some place, just like they were an adult offender.

Mr. **Richardson**. Is there anything that some of your staff would like to add related to the drafting of this bill or any changes or recommendations that you would have?

Mr. Sota?

Dr. Welch, seems like a loquacious guy. He started out strong but hasn't said much, here is your chance.

Mr. **McCoy**. I would favor the family and community as a focal point for this kind of effort, Mr. Chairman. We are dealing with a pervasive problem and one that takes support from many different sources.

There is some question as to how much Native Americans constitutionally are equipped for dealing with alcoholism. Certainly, they have not had the long amount of social experience that other groups and societies have had in dealing with the problems to develop social controls for it.

And I say I would much prefer a family oriented kind of approach, but it has to move into the schools. It has got to go out into the total community.

It has got to make use of all kinds of resources there are available every place. We have got to bring this to bear, to make use of them to deal with this problem. It is killing the people.

Mr. **Richardson**. Thank you.

Mr. **McCoy**. I appreciate the interest and concern on the part of Congress in providing some resources to deal with this problem.

Mr. **Richardson**. Thank you, Doctor.

Mr. Sota.

Mr. **Sota**. Yes; I think I take a unique position in this area because we deal with off-reservation boarding schools, and in terms of the off reservation boarding schools we in a sense, are in loco parentis to a degree. And in there we do have the responsibility for the residential care as well as the academic, and therefore, in terms of the question of family or student, of course, we would say we would have to look at a provision on student services to be provided.

That doesn't necessarily mean that the family needs to be neglected at this point. One of the areas that we are looking at in terms of objectives for next year, or the coming year, or in relationship to this particular program is that we need to communicate with the families, we need to work out relationship with the family community so that we can provide the services to the students because they do return to their reservation.

In hearing the testimony today, I find that we need to have greater communication in terms of these services or the agencies at the reservation level, as well as, within our own schools.

The other thing, at this time we find that to provide these services and to look at the relationships between the government relationshp with the tribes, there is a concern in terms of the funds, the level of funding, the providing of services. I terms of this area, someone is going to have to—I guess, I can relate this too in terms of a health maintenance organization—someone is going to have to foot the bill, because no one can totally foot the bill themselves, in terms of agencies such as that. We need to take a look and see how we can effectively and efficiently operate a program, the services that we consider as a No. 1 priority in the schools.

Thank you.

Mr. RICHARDSON. Thank you very much.

How about the gentleman on the far right.

Mr. BURNS. Thank you, Mr. Chairman.

I am Dr. Burns from the Phoenix, AZ, office. I would like to echo the sentiments and comments our colleagues have made. And I would like to respond somewhat to the question you addressed to Dr. McCoy.

I feel very strongly the Congress should be commended, our committee in particular, and the staff persons for developing legislation dealing with a very overwhelming kind of problem.

Specifically, the reason I feel that is that in terms of being a staff person dealing with contract-related issues, the majority of funds that I see going into contract programs deal with the casualities of alcoholism, ones much like the medical problems the Indian Health Service deals with directly.

The contract programs are also doing that. If we are going to impact on the Indian substance abuse, the legislation that you are working for, I think, is a couragous step forward dealing with the youth.

I think that as we begin to deal with whole families, teenagers, and younger children, the incidence rates will only be impacted, and this must be done with initial support, not necessarily the dollar amounts limited by that legislation.

The problem that we are facing currently on a contractual level really requires substantially more dollars to deal with family currently in-house. I feel very strongly generally to deal with impacting the prevalence rates, we must deal with the youth. I think your legislation supports that in a very courageous step forward.

Thank you.

Mr. RICHARDSON. Let me conclude by asking both area directors for the BIA and IHS, why when it comes to alcoholism isn't there any formal agreement or memo of understanding when it comes to defining activities of subunits, and referrals for outpatient or inpatient facilities?

Shouldn't we have one?

Mr. REDDING. From the IHS perspective, we have felt, generally speaking, that it is a local cooperative effort, and as I mentioned, most of the contracts we have turned over to management and assistance levels of the service units, and we find that it seems to be a little easier—again, I think in full light of Indian self-determination—to have this done at the local level.

There have been attempts made at headquarters in Washington to come to some sort of agreement, but it is difficult to relate to an agreement that can encompass the eastern tribes; for instance, in Oklahoma, and also the Supai Tribe in the Grand Canyon.

Some of these particular problems we find are easier to solve at the local level.

Mr. RICHARDSON. Wouldn't something in writing make things a lot easier so there is no duplication? You are still fulfillng the local level responsibility.

Mr. Stevens, what do you think?

Mr. STEVENS. Well, Mr. Chairman, I think this is one of the reasons why you are asking, and why you have been getting positive responses from the tribes during the program. If the tribes run the program, it is going to have a real chance of succeeding.

I would also like to suggest some of your people and our people get together as to the mechanism of giving the money to the tribe because the mechanisms we have right now are generally either grant funds, or 93638, and both require administrative overhead and administrative costs.

The one area we have in all our programs that could be tied to alcoholism would be social services. Social service grant moneys are not set up for alcoholism programs.

Our social workers are involved in counseling, but the Bureau has a policy, and it is pretty clearly stated, and we received our copy in 1982, that this is primarily an IHS area, and it is an area they have the responsibility for.

Now, obviously at the Agency level, the field level, our people in social services are working with IHS to try and help them on some of the programs that are ongoing, but I think this is generally the extent of that.

Mr. RICHARDSON. I want to thank all the witnesses, and I want to thank all those that have stayed throughout this hearing.

The Committee on Interior and Insular Affairs is thus adjourned, and we thank all for participating.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

APPENDIX I

TUESDAY, MAY 28, 1985

ADDITIONAL MATERIAL SUBMITTED FOR THE HEARING RECORD

HONORABLE JOHN MCCAIN
OF ARIZONA
IN THE HOUSE OF REPRESENTATIVES
MAY 28, 1985

MR. CHAIRMAN, IN RECENT MONTHS DRUG AND ALCOHOL ABUSE HAS,RIGHTFULLY SO, BEEN HIGHLIGHTED NATIONALLY. THIS IS THE FIRST STEP IN TREATING THE DISEASE--THE RECOGNITION OF THE EXTENT OF ITS EXISTENCE. NANCY REAGAN'S RECENT CAMPAIGN IS A GOOD ILLUSTRATION OF WHAT EDUCATING THE PUBLIC ABOUT THIS TERRIBLE PROBLEM CAN DO TOWARD ITS FIGHT. SHE HAS NOW BROUGHT TOGETHER THE WIVES OF THE LEADERS OF 17 NATIONS TO DISCUSS COORDINATED EFFORTS IN THEIR RESPECTIVE COUNTRIES TO FIGHT THE CAUSE AND TREAT THE ILLNESS.

TODAY, MR. CHAIRMAN, WE ARE HERE IN RAPID CITY TO EXAMINE ONE ASPECT OF THIS NATIONAL PROBLEM -- DRUG AND ALCOHOL ABUSE AMONG OUR INDIAN YOUTH.

I WOULD LIKE TO COMMEND CHAIRMAN UDALL FOR SCHEDULING THIS SERIES OF IMPORTANT HEARINGS, AND THANK MR. GEJDENSON FOR CHAIRING TODAY'S HEARING. I WOULD ALSO LIKE TO COMMEND MR. BEREUTER FOR HIS TIRELESS DEDICATION, AS THE FORMER CHAIRMAN OF THE REPUBLICAN TASK FORCE ON INDIAN AFFAIRS, TO HELP OUR NATIVE AMERICANS, ESPECIALLY IN COMBATING JUVENILE DRUG AND ALCOHOL ABUSE.

THE PROBLEMS AMONG OUR AMERICAN NATIVES ARE PERVASIVE WITH HIGH UNEMPLOYMENT, POOR HOUSING, INADEQUATE HEALTH CARE AND THE PERCEPTION OF LITTLE OR NO FUTURE ON THE RESERVATION. UNFORTUNATELY, TOO MANY OF OUR INDIAN YOUTH RESORT TO DRUG AND

ALCOHOL ABUSE. I AM NOT JUST TALKING ABOUT THE BEER BLAST OR THE SMOKING OF MARIJUANA--BUT OF EVEN MORE TERRIBLE ABUSE. ON SOME POOR RESERVATIONS WHERE THE "HOLLYWOOD' GLAMOUR DRUGS LIKE COCAINE DO NOT EXIST, SOME INDIAN YOUTH RESORT TO USING INHALANTS LIKE GASOLINE, STERNO AND EVEN HOUSEHOLD ITEMS SUCH AS LYSOL SPRAY.

FROM THE DAKOTAS TO OKLAHOMA TO MY HOME STATE OF ARIZONA THE PROBLEMS OF DRUG AND ALCOHOL ABUSE SHOULD BE LABELED EPIDEMIC. THE VARIOUS PIECES OF LEGISLATION BEFORE THE COMMITTEE (H.R. 2624 AND H.R. 1156) ARE DIRECTED AT BEGINNING TO ADDRESS THIS PROBLEM THROUGH COOPERATION, EDUCATION AND COUNSELING WITH A GOAL TOWARD PREVENTION.

IT IS A COMPLEX PROBLEM WITHOUT EASY ANSWERS--WE CANNOT JUST APPROPRIATE MONEY AND WISH THE PROBLEM AWAY. HOWEVER, WITH THE COORDINATED DEDICATION OF LOCAL LEADERSHIP, WE CAN BEGIN DOWN THE RIGHT PATH.

I PROPOSE THAT TO THE GREATEST EXTENT POSSIBLE DRUG AND ALCOHOL ABUSE PROGRAMS BE PLACED IN LOCAL CONTROL. TRIBAL GOVERNMENTS OR ENTITIES WITHIN THE TRIBES KNOW MUCH BETTER THE EXTENT OF THE PROBLEM AND HAVE AN UNDERSTANDING OF THE INTERRELATIONSHIP BETWEEN THE ABUSE AND OTHER RESERVATION AND TRIBAL PROBLEMS.

HOWEVER, SINCE THIS IS A NATIONAL PROBLEM WITH OVERLAPPING CAUSES, I ALSO PROPOSE THAT EXISTING AND NEW FEDERAL PROGRAMS BE BETTER COORDINATED AND FOCUSED. PROGRAMS CURRENTLY EXIST IN THE DEPARTMENTS OF THE INTERIOR, OF EDUCATION, AND OF HEALTH AND HUMAN SERVICES. WITHOUT A COORDINATED EFFORT, DUPLICATION AND CONFLICTING SOLUTIONS CAN NEGATE SOME OF OUR BEST EFFORTS.

I HAVE ALWAYS BELIEVED THAT EDUCATION IS THE KEY TO MANY SOLUTIONS. IT MAY NOT BE THE ANSWER TO THOSE ALREADY RACKED BY THE DISEASE BUT IT CAN GO A LONG WAY TOWARD PREVENTING MANY OF OUR YOUTH FROM EXPERIMENTING WITH OR ABUSING DANGEROUS DRUGS, INHALANTS, OR ALCOHOL. COOPERATION AMONG THE VARIOUS AGENCIES IS EXTREMELY IMPORTANT IN THIS AREA BECAUSE OF THE MANY ROLES THE FEDERAL GOVERNMENT HAS IN THE FIELD OF INDIAN EDUCATION.

IN ADDITION TO SEARCHING FOR LONG-TERM SOLUTIONS TO THE ABUSE--THROUGH EDUCATION AND COUNSELING--I RECOGNIZE THAT ON MANY RESERVATIONS A CRISIS HAS DEVELOPED. H.R. 2624, THE SECRETARY OF HHS WOULD BE DIRECTED TO IDENTIFY THESE CRISIS AREAS, COORDINATE THE MANY PROGRAMS WITH IN HHS, AND CONCENTRATE THE AVAILABLE RESOURCES IN THE CRISIS AREAS TO COMBAT THE DISEASE. I AM NOT TALKING ABOUT ONLY THE RESOURCES OF THE INDIAN HEALTH SERVICE, BUT FROM THROUGHOUT THE HHS. THE IHS HAS MANY DUTIES IN THE FIELD OF HEALTH CARE--SOME WHICH DEAL WITH DRUG AND ALCOHOL ABUSE. HOWEVER, THE EXPERTISE IN THE HHS ABOUT THIS DISEASE IS IN THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION. THEREFORE, H.R. 2624 WOULD ELEVATE THE RESPONSIBILITY FOR INDIAN YOUTH DRUG AND ALCOHOL ABUSE PROGRAMS TO A NEW COORDINATING OFFICE WITHIN THAT ADMINISTRATION.

IT IS MY HOPE THAT THE EXPERTISE ALREADY EXISTING CAN BE QUICKLY FOCUSED ON THE INDIAN YOUTH DRUG AND ALCOHOL ABUSE PROBLEM. THE KEY TO LONG-TERM SUCCESS IS WITH THE YOUNG PEOPLE OF THIS COUNTRY--WHETHER THEY ARE INDIAN, BLACK, WHITE, POOR OR EVEN ADVANTAGED--WE MUST DO WHAT WE CAN TO DEVELOP THE OPPORTUNITIES OF ALL OUR PEOPLE THROUGH OUR MOST PRECIOUS RESOURCE--OUR YOUNG PEOPLE.

I REALIZE THAT MANY GOOD IDEAS EXIST ABOUT HOW TO ADDRESS THE PROBLEM FROM THE ASPECT OF A FEDERAL RESPONSIBILITY. I AM NOT OPPOSED TO OTHER LEGISLATIVE IDEAS, BUT I DO WISH FOR A FULL EXAMINATION OF MY IDEAS ALONG WITH OTHERS, SO THAT WE, AS LEGISLATORS, ENACT SOMETHING TO ACTUALLY HELP OUR INDIAN YOUTH AND NOT JUST EXPAND BUREAUCRACIES. IT IS MY HOPE THAT A CONCENSUS WILL FORM ON THE BEST SOLUTION TO HELP OUR INDIAN YOUTH.

STATEMENT OF MORGAN GARREAU, CHAIRMAN, CHEYENNE RIVER SIOUX TRIBE, BEFORE THE HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS, REGARDING H.R. 1156

Mr. Chairman, I am Morgan Garreau, Chairman of the Cheyenne River Sioux Tribal Council. I appreciate this opportunity to testify on the proposed Indian Juvenile Alcohol and Drug Abuse Prevention Act.

Mr. Chairman, alcoholism is a problem that has plagued our people for generations. Sadly, the condition is one passed from parent to child. It would seem that the alcoholic parent almost inevitably leads to alcoholic children. This is due to physiological factors to some extent. The greater causes, however, seem to be social and psychological. If Indian alcoholism is to be controlled in our lifetime, the answer clearly is to avoid producing another generation of alcoholics. We must, therefore, devote every available resource to the prevention of alcohol and drug abuse among our young people.

To this end, the proposed bill represents a huge stride forward. By directing BIA and IHS to work together, the historic reluctance of BIA to involve itself in this most unhappy aspect of Indian life may be overcome. By requiring IHS to devote more resources to the problem, the bill will cause those resources to be applied to the single greatest health problem of Indian people today. And by focusing on the prevention of alcoholism among young people, the most important resource of Indian tribes -- our young people -- will be allowed to reach their full potential and lead our people beyond the poverty, ignorance and disease that we have suffered for so long.

Turning to the specific provisions of the bill, we support fully Title I of the bill, which requires BIA and IHS to coordinate all available resources for the prevention of juvenile alcoholism. We also support Title II, which mandates that alcohol and drug abuse counseling be provided in Indian schools, and provides that currently available funds be devoted to the training and education of counsellors in the area of alcohol and drug abuse prevention. We are concerned, however, about the provision requiring that ten percent of the fellowships awarded under the Indian Education Act go to persons receiving training in alcohol counseling. This amount is at once too much to take from other educational endeavors and too little to provide funds for the number of alcoholism counsellors needed in Indian country. We recommend that a fellowship program be established and funded independent of the existing program.

We also are concerned about the provisions requiring 638 contract schools to offer programs of instruction on alcoholism. Our concern is not based upon disagreement with the concept but, rather, with the fiscal impact of such requirements on already-strained school budgets. If additional funds are made available to these schools, of course, this concern is answered.

Title III of the bill deals with family and social services. We support the concept of making available training to government personnel on the matter of alcoholism. We believe, however, that such training should be mandatory for the federal government personnel listing in paragraph 301(b)(1).

We also support Title IV of the bill. It is imperative that law enforcement personnel on Indian reservations be trained adequately to deal with juvenile alcohol and drug abuse. We also appreciate the fact that the bill shows due deference to tribal law, while still authorising alternatives to the incarceration of juvenile alcohol abusers.

Title V of the bill touches upon an issue of great importance to my Tribe. In 1980, the Cheyenne River Sioux Tribe was sued in an effort to improve conditions at the Tribal jail. In settlement of this claim, the Tribe had to agree to make a number of improvements to the existing jail, which was built and is owned by BIA, and to provide a separate facility for the detention of juveniles. Despite four years of effort, we have been unable to persuade the Bureau to make provision for the necessary repairs and construction.

Mr. Chairman, the Tribe does not want to see delinquent children become adult criminals, nor do we wish to have Tribal offenders jailed in unnecessarily poor facilities. Punishment is only one aspect of criminal justice. Far more important aspects of criminal justice are the rehabilitation and, where appropriate, treatment of offenders. We cannot provide a proper rehabilitation program to inmates when the facilities are in greater need of rehabilitation than the inmates. Equally important, we are unable to meet the Court-ordered standards imposed in the 1980 lawsuit.

We emphasize that if the Tribe were not contracting the Law Enforcement Program on the Reservation, the BIA would have been the defendant in the 1980 lawsuit. Although BIA is requesting

$79,000,000 in facilities operation and maintenance funds for F.Y. 86, our request for renovation and expansion of the detention facilities has received such a low priority that no part of those millions is scheduled to be spent on the Cheyenne River jail. Moreover, the Bureau makes no request for construction monies. Thus, no funds for the construction of a juvenile detention facility will be forthcoming.

Mr. Chairman, we are left in an untenable situation. Under the Self-Determination Act, we contracted in good faith to operate the Law Enforcement program using BIA facilities. Those facilities are inadequate and unlawful, yet BIA refuses to upgrade its facilities. If we are unable to force the Bureau to meet this request, we face a very difficult situation. One option open to us is to retrocede the Law Enforcement contract. In fact, we have no intention of retroceding. We would note, however, that if Secretary Hodel and BIA officials were the defendants in the Court proceedings instead of Tribal officials, funds for the necessary repairs and construction undoubtedly would be found.

Much of the serious crime on our Reservation is alcohol-related, particularly among juveniles. We urge that a provision be included in this bill requiring BIA to give the renovation, expansion and construction of juvenile detention facilities top priority in future facilities maintenance funding allocations.

Mr. Chairman, again I express my appreciation for this opportunity to testify. I would be happy to try to answer any questions you might have.

My name is Greg Miller. I am the Director of the Lower Brule Sioux Tribe Alcoholism Program in Lower Brule, South Dakota, and I am an alcoholic.

1. General Observations

The Lower Brule Sioux Tribe fully supports the intent and the various provisions of H.R. 1156 and urges passage by the committee and the full house.

As may not be contestable and may instead be well known, the illness of alcoholism and the abuse of alcohol and other controlled substances is a disease of pandemic proportions in Indian communities. There is not one family on most reservations in South Dakota that is not in some way affected by this disease.

This disease and its destructive force has for too long been ignored or minimized by the service delivery systems in place. Administration after administration, congress after congress, and tribal governments have continued almost as if unconscious of the enormity of this disease. H.R.1156 at long last recognizes the severity of the problem and seeks however half-heartedly to address it.

If anything, the bill does not go half far enough. It adds education and interjurisdictional dimensions in delivering services to those affected by the illness. But five (5) million dollars seems hardly an adequate authorization to fully attend to the situation.

Somewhere in the bill there could be perhaps added a provision to require Indian Health Service's epidemiology to include all alcohol and substance abuse relationships of illnesses reported. Failure to do so has consistently not provided information to decision makers regarding the true cause of such health problems as trauma caused by violence or accident, diabetes, hypertension, heart failure and even -because of parent neglect- massive cases of upper respiratory infection and unnecessary dehydration or malnutrition in children younger than 5.

If the level of illness affecting Indian people today in this country was suffered by any other population group, national fund raising agencies would rush to find a cure. Not five (5) million but billions of dollars would be raised annually to identify causes-to isolate persons affected by the disease from others who certainly will become infected by it. Treatment regimens would be studied, restudied and made the object of Nobel prizes. In fact, the neglect shown this problem by the government of the United States will be judged by other nations and future generations as a genocidal crime similar in proportion to the nazi decimation of the Jews.

So while we applaud the bill we decry the fact that it has taken so long for it to be proposed.

2. Comments about Specific Provisions of the Bill

More particularly as to specific provisions of the bill, the memorandum of agreement mandated in Sec. 101.(a) must not be allowed to repeat the process of chasing a problem with paper bugun by the Merriam Report and continued on through the generations up until as recently as the seventies when the same two agencies, Bureau of Indian Affairs and Indian Health Service were required to act in a similar fashion in regard to the education of the handicapped.

Indeed throughout the last sixty years studies, reports, and other memoranda of agreement have continued to be written and the problem-like alcoholism and substance abuse-has continued to worsen year by year.

What has to be done--not at the highest level but at the lowest level of government--is the development of service delivery systems that are based on client need and not agency, bureau or departmental regulations.

In Title II, Sec. 204, some direction should be provided local education agencies to intervene when it becomes apparent that a child is affected by alcohol or substance abuse. Instruction without intervention tends at times simply to raise the awareness of children of the variety of methods that remain for them to experiment with. Therefore the schools must begin to understand their responsibilities to include outreach into family environments and after-care situations as well as in class instructional activities.

In Title III, the act should also require education in the problem as well as more and more effective treatment plans.

A major problem at the local level in dealing with alcohol and substance abuse as also with other social pathologies, the chief deterrant to wellness has been the inclination of service providers to find another agency than themselves whose resposibility it is to deal with a client's problem.

In Title IV, the idea of developing temporary emergency shelters in community based facilities could provide an excellent alternative to incarcerations which have not proved to be rehabilitative, but only if persons capable of showing "tough love" could be found to staff these centers.

3. Summary

In general then, the tribe that I represent is much in favor of H.R.1156 and if anythâng urges that it be strengthened by increasing the funding authorization and strengthening some of its provisions.

Thank you for the opportunity to present this testimony.

Greg Miller, Director of Alcoholism Program
Lower Brule, South Dakota

RICHARD L. KITTO
CHAIRMAN

Testimony on H.R. 1156 "Indian Juvenile
Alcohol and Drug Abuse Prevention Act."

Gentlemen:

We, the members of the Santee Sioux Tribe of Nebraska fully support the intent of H.R. 1156, and are extremely gratified that our Congressman, the Honorable Douglas Bereuter, is a sponsor of the legislation that will directly impact an are of great concern.

The Indian youth on the many reservations are confronted with questions about and pressure to utilize/abuse alcohol and drugs. We feel that young people, if properly educated about the many related problems of abusing alcohol and drugs, would have the ability to say no, and understand why they are saying no.

The lack of alternatives to the use of substances is a problem encountered not only by our tribe, but many of the tribes throughout the nation.

We, as a tribe, lack the recreational facilities, funds, and adult involvement to consistently offer alternatives to our young people. We envision that one or two adults cross trained in the various aspects of drug/alcohol abuse by youths, would have a substantial impact on this problem. If our facilities were improved, with adequately trained adults, many activities could be created in intramural sports, team activities, and programs for all ages of youth.

Much of the abuse that occurs results from the lack of parental involvement. If parents had access to education programs designed to instruct in inter-family relations, many of the young people would be able to take their problems home to their parents. We strongly believe that Indian parents love their children and want only the best for them, but the strong need to provide for daily existence has left this side of parenting uncultivated.

We believe that education as an alternative should start at an early age, that curriculum should be developed for Head Start Programs, as well as K-12 systems. We believe that instructors and counselors in these systems should be educated about alcohol and drug abuse.

It is our opinion that instructors, and Community Health Representatives, should be the primary training recipients. They are the front line personnel to identify and deal with the resultant problems.

We do not believe it necessary to create another level of management in the government to assist in dealing with this problem. The Bureau of Indian Affairs and Indian Health Service as it exists, should be able to identify available resources and present that information to the tribes.

We believe each tribe should be able to take the amassed information and develop a plan, to effectively offer alternatives and prevention programs to combat the abuse of alcohol and drugs by our youth. The BIA/IHS should be in a Technical Assistance Capacity, rather than the direct program presenters.

We would like to point out that one plan will not meet the needs of each tribe. Though we all share this common problem, each tribe is individualistic on how it resolves its problems, based on the many characteristics of its location and demographics.

We believe that if this legislation is passed as drafted, the creation of another management level, stated training, and compiling of information would exhaust the requested appropriation without any direct impact on the reservations.

Tribes should be able to contract for portions of training and be involved extensively in compiling of facts and recommendations for program implementation. We strongly support P.L. 93-638 or Self-Determination in trying to resolve problems that directly impact our destiny.

In closing, we would like to supplement our testimony with that of the United Tribes for Reservation Youth, formerly the Aberdeen Area Committee on Youth. Many of our concerns and ideas are in conjunction with the committee's.

We would like to thank the committee for giving us this time and opportunity to express our views on H.R. 1156, **"Indian youth Alcohol and Drug Abuse Prevention Act."**

Respectfully submitted

Richard L. Kitto

Richard L. Kitto, Chairman
Santee Sioux Tribe of Nebraska

RLK:kk

Turtle Mountain
Native American Youth Alcohol Education
BOX 900
BELCOURT, NORTH DAKOTA 58316

KENNETH "RUSTY" PARISIEN
Coordinator
Ext 165

PHONE 477-6451

BARBARA POITRA
Coordinator
Ext 164

My name is Barbara Poitra, and I am representing the Turtle Mountain Band of Chippewa in Belcourt, North Dakota.

I would like to share with you some information about a Prevention Program that is established and is working in our great State of North Dakota.

I read the draft of the Bill that is being proposed today, and I thank the Great Spirit for an answer to a prayer of mine. I have dreamed of having this kind of a Program for Indian Youth for many years. We have a program like this on all four reservations in our state, but there is a need to do much more than we are doing right now. The biggest problem to overcome is naturally, the finances to operate. One of our biggest assets is that we have had four years to establish ourselves, and find the areas that work best for our people. Native Americans need specialized treatment. The past has proven this, and we have set up our individual programs to fill this need.

In your packets you will find some statistics that you might find useful. As you can see, on our reservation we have contacted over 30,000 children. This is of course, counting the same ones over and over again, but we have found that you need to do that. The total number for the past four years will be higher as we make the final count on June 30, 1985, which is the end of our fiscal year. All the school personel have also recieved training in the area of alcohol/drug abuse. I am here today to tell you that the prevention program is a successful endeavor. We believe that if we are going to be able to do anything about the number one killer of our people, it is in educating our people, and treating them for their addictions.

The cost per student is very minimal. In our first two years of operating, we had a Summer Program that provided not only alcohol/drug education, but many fun activities for children ages, 5-21. The cost per student was: $ 20.00. When you are comparing this cost with the cost of treatment, it is unbelievable. The cost for one person to recieve four weeks of intensive treatment is over $3,500.00. I am using costs from our treatment centers in North Dakota, but I don't think they are much different any where else.

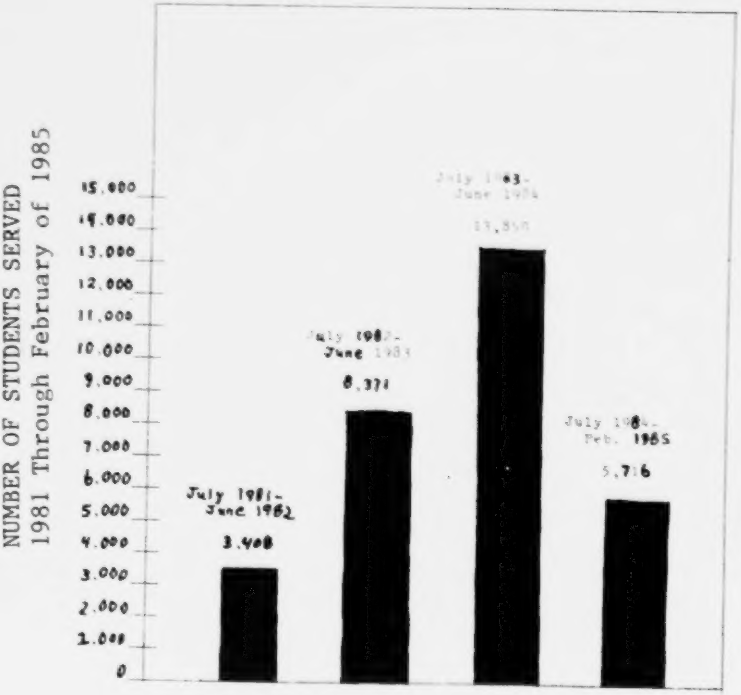
Preventing a problem is much wiser than treating the problem later. As you can see there is a big difference between the two.

I strongly urge you to pass HR-Bill 1156 because of the need for prevention programs on all reservations. For instance, on our reservation, all fatal automobile accidents were alcohol or drug related. All fatal homcides were alcohol/drug related. The suicide rate for Native American Youth is ten times the national average. We could go on for hours quoting statistics, and telling you about how these chemicals affect our youth, but I think it's general knowledge. Passing this Act would save thousands of our children, and I believe there is no greater goal than saving our youth from a slow suicide, from alcohol/drugs.

There are some letters and short evaluations on our program in your packets. I urge you to take the time to read them, and if you would like more information, please feel free to call us any-time. I would like to leave you with this thought from Dr. Uri Lowental, out of the New York Times, October 26, 1975,"...Human life is unique, cannot be recovered and has to be saved at almost any cost." This is how I feel about our youth. Their lives must be saved from alcohol/drugs at almost any cost.

Thank you for your time and attention. I am honored to have been able to speak to you today.

GRAPH OF STUDENTS SERVED IN THE PAST
3½ YEARS.



Turtle Mountain
Native American Youth Alcohol Education
BOX 900
BELCOURT, NORTH DAKOTA 58316

KENNETH "RUSTY" PARISIEN
Coordinator
Ext. 185

PHONE 477-6451

BARBARA POITRA
Coordinator
Ext. 184

HIGHLIGHT NEWS FROM BELCOURT!!!!!!!!!!

In the future we hope to send these Newsletters on a regular basis. We will be mailing them to the State Legislator's and Indian Affairs Commission. If anyone would like to be put on our mailing list, please let us know.

Kenneth "Rusty" Parisien and Barbara Poitra are now Co-Coordinator's of our program in Belcourt. This was approved at the beginning of the fiscal year, 83-85.

There are now six are schools that have Alcohol/Drug curriculum in the classroom. We have plans for 2 more before May, 1985. In addition to the curriculum, we still do In-class workshops, and keep the students information up-dated. In-service workshops are done for the teachers, parents, and professionals in the community too. The total number of students recieving our services is: 5, 280.

The Community Youth Center at St. Benedict's is now a reality. We have two HIgh School Clubs using the facilities, and the Community College is teaching a Racquet Ball Class for Credit during the winter Quarter. We have maintained this Center with different Fund raising activities, and private donations. In the Summer of '84, we had educated 286 youth in the area of alcohol/drug abuse. They also participated in many fun activities and sports events at the Center. We were unable to run our usual Summer Program because of lack of funds.

We have some really good news for the community: the Belcourt Police Department reports that the rate of arrests and truancy violations for our youth is done by 30%, and that it has been on a steady decline for the last two years. We would like to think that the reason for this is because of our hard work.

The Turtle Mountain Cultural Club, which Barbara directs, is one of the childrens favorite activities at the school. They sell their arts and crafts to keep the program going.

Did you know that Belcourt Community High School had the only S.A.D.D. Council in the state of North Dakota till March of 1985? Youth alcohol works with these students on a regular basis, and also works with the alcohol coulselor's at the schools. Barbara takes her B.A.B.E.S. Program to all the area schools in grades K-6th. She also takes the puppets to the Headstart Schools in the area.

Youth alcohol has many other activities planned for the next two years, providing our Legislator's fund the program again. We recieve many requests for our services, and for information about alcohol/drug prevention programs. Barbara has done workshops for: National Indian Child, North Dakota Indian Education, The University of North Dakota, Indian Tiem Out, and many other local and State Institutions. This hsows there is a thirst for knowledge in the areas of alcohol/drug abuse. We need to stamp out the number one killer of our people, "alcoholism," and keep our children educated about all the chemicals that are harmful, and keep teaching them lifeskills that will help them learn that they are very special, unique individuals, and we love them above all else.

TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS
TURTLE MOUNTAIN TRIBAL OFFICE
Community Center Building Belcourt, North Dakota 58316
(701) 477-6451

January 7, 1985

Appropriations Committee
State of North Dakota
State Capitol
Bismarck, ND 58501

Dear Committee Members:

A year ago, I testified before your committee that the best program that the State of North Dakota has provided and implemented for the American Indians is and has been the Youth Alcohol Program. It is my opinion that that testimony still stands.

I believe the program to be very well run and received by the Indian people of the state. The amount of dollars are very cost effective in their far reaching effect. The Tribes in North Dakota can be very proud of their efforts in putting together this program and funded by the State. The Turtle Mountain project is being classified and called to model Youth and Alcohol Prevention projects to all Indian Tribes in this country. I think a compliment must be presented by not only the Tribes but also the wisdom of the Legislature to so endorse this program.

I request your support again this year, for prevention is not measured in a short term effect. Any further questions can be referred to my office.

Respectfully,

Richard J. LaFromboise, Esq.
Tribal Chairman

RJL/jp

Turtle Mountain Agency Schools
SPECIAL EDUCATION
Belcourt, North Dakota 58316

January 7, 1985

Kenneth Parisien
Youth Alcohol Education Program
Belcourt, North Dakota 58316

Dear Kenneth:

I heartily endorse your efforts in working to alleviate the alcohol related problems that plague our reservation youth.

Educational programs and other prevention programs you have begun are essential to begin to reverse the attitudes that have created many problems for youth. Most problems, as you know, are alcohol related. Continue your efforts and thanks for your cooperation in our school efforts also.

Sincerely,

Paul Dauphinais, PH.D.
School Psychologist

Ojibwa Indian School BELCOURT, NORTH DAKOTA 58316

[illegible] 477 3108
[illegible] 600

January 4, 1984

Mr. Kenneth Parisien
Native American Youth Alcohol &
Drug Education Program
Belcourt, ND 58316

Dear Mr. Parisien:

I'd like to personally thank your organization for the time, effort, and support you've given us in helping our students become more aware of drug and alcohol prevention. Your assistance and monies in helping our school purchase the ME-ME Program, a Drug Prevention Education Program is much appreciated. The program continues to be implemented in grades K-6, affecting approximately 270 students. Being that most drug and alcohol abusers have poor self-images and an inability to cope with everyday problems in life, this program continues to address these concerns. The program continues to help our students improve their: self-concepts, decision-making skills, attitudes toward proper drug use, and knowledge about drugs.

Furthermore, we have enjoyed the variety of activities that your organization has provided the school during Alcohol and Drug Awareness Week and look forward to this year's events. The classroom presentations dealing with alcohol and drug prevention continue to be needed and appreciated. The speakers from the community have also provided a great deal of information to our upper grade students in the areas of alcohol and drug abuse and the law, and the fetal alcohol syndrome. The tours to the local detoxification and treatment units have been informational and have increased the students' knowledge of alcohol and drug treatment.

As a counselor, I continue to see many students who live with alcoholic parents and have problems coping with the alcohol abuse. Consequently, your program continues to be needed in both the school and community.

Thanks again for your continued efforts at raising our students' awareness of alcohol and drug abuse.

Sincerely,
Karen Kerkvliet
Karen Kerkvliet
School Counselor, NCC

Disposition of Alcohol Revenues

THIS ROAD
BUILT
BY
LIQUOR-TAXES

Federal alcohol revenues are deposited in the U.S. Treasury and they are expended at the direction of Congress. There are no earmarked federal alcohol taxes.

State alcohol revenues are a different story.

All 50 states and the District of Columbia channel the major share of their alcohol revenues into the state's general fund where lawmakers have the flexibility of appropriating this, along with other state monies, to a variety of state services.

Most states also share in some way their alcohol revenues with cities, counties, townships or some other form of local government. Only New Hampshire, Connecticut, Delaware and Maine do not share alcohol revenues with local units of government in some way. In the case of Washington, D.C. all monies go to the federal government which is responsible for the city's budgetary needs in total.

In 14 states, there is a special provision in the law for using a portion of alcohol revenues for expenses incurred with that jurisdiction's Alcoholic Beverage Control (ABC) board's functions. This would include expenses for licensing and enforcement of state liquor laws.

18 of the states have a monopoly system of control, whereby the state acts as the wholesale outlet for distilled spirits. All of these jurisdictions use at least a portion of their alcohol-related revenues for store operations as well as other merchandising or enforcement expenses.

In 13 states, there is provision for a portion of alcohol revenues to be used for prevention, education and treatment programs for alcoholism and other alcohol-related problems.

Where there is earmarked alcoholism funding, in no instance is that the only source of that state's alcoholism budget. In all cases, the earmarked alcohol revenues represent only a portion of what is spent for alcoholism services.

The next most common allocation of alcohol revenues is for the purpose of general education. In 8 states, alcohol revenues are earmarked for school or educational purposes.

In 5 states, a portion of alcohol revenues is earmarked for pensions or retirement funds of the state's elderly population, while 3 states earmark alcohol revenues in part for general welfare purposes. In 4 states, there is a provision for a part of state alcohol revenues to go to the state's mental health fund.

The accompanying chart will show other purposes for which alcohol taxes have been earmarked. These purposes include such diverse services as township fire protection in Ohio, playgrounds in Tennessee, rural roads in Texas and medical research in Washington.

The rationale of earmarking alcohol revenues varies from state to state. It seems logical that a portion of alcohol revenues might be spent for liquor merchandising in the case of monopoly states, for liquor licensing and enforcement, and for alcoholism programs.

However, it is more difficult to identify the logic in earmarking alcohol revenues for other services.

Perhaps the common thread running through other sources which benefit from earmarked alcohol revenues is that such monies in many cases are considered taxes on "luxury" items, and are therefore regarded as relatively "painless taxes."

Since these are user-taxes, nondrinkers do not pay this assessment. This is significant, too, because approximately one-third of the U.S. adult population does not drink. Another one-third drinks seldom and therefore pays little of any alcohol taxes assessed.

The two studies are not comparable, he said, because the difference between them stems from methodological changes, price and wage inflation and population growth factors.

RTI noted that fundamental improvements had been made, including the addition of costs of fetal alcohol syndrome. Estimates on productivity losses from alcohol abuse have also been improved and refined from the earlier work.

With the availability of the RTI study, lawmakers are expected to ponder increases in alcohol taxes not as the windfall they once did, but to help recover at least a part of the enormous price that society is paying for alcohol abuse and alcoholism.

The fifth Special Report on Alcohol and Health to the U.S. Congress, released earlier this year, suggests still another criterion for boosting alcohol taxes.

The report sets forth 13 specific goals as "1990 Objectives."

Among those goals is the reduction of motor vehicle crashes, cirrhosis mortality and other alcohol-related problems, along with a stabilizing of the current per capita consumption levels for alcoholic beverages.

And just how are these goals to be achieved?

Several strategies are suggested, including *taxation*.

The use of alcohol taxes as a prevention strategy is now being considered because of the growing number of studies which indicate that taxes can have a positive effect in reducing alcohol problems.

Since publication in 1981 of the Fourth Special Report to Congress on Alcohol and Health, a number of studies have been published exploring the implications of legislative and regulatory approaches for the prevention of alcohol problems.

In collaboration with the World Health Organization (WHO), the International Study of Alcohol Control Experiences (ISACE) has reviewed historical patterns of alcohol consumption, problems, policies and their effects in Finland, Ireland, the Netherlands, Canada, Poland, Switzerland and the United States.

One of the conclusions of the ISACE study is that there is a relatively large econometric literature on the relation of alcohol taxes and prices to consumption of alcohol and alcohol-related problems.

In particular, Cook and Tauchen (1982) estimate that an increase in the liquor excise tax by $1 (1967 prices) per proof gallon (viz., 64 ounces of ethanol) would reduce the liver cirrhosis mortality rate by 5.4 percent in the short run and perhaps by twice that amount in the long run. Cook also offers a historical example: When France imposed stringent wine rationing in 1942, the cirrhosis mortality rate in Paris fell from 35/100,000 in 1941 to 6/100,000 in 1945-46, only to return to its previous higher levels when rationing ceased in 1948. Other work (Mello 1972; Nathan and Lisman 1976) offers clinical evidence that alcoholic persons do reduce their alcohol consumption as a function of the beverage costs.

Cook (1981) also found that increases in the tax rate of spirits will reduce both the auto fatality rate and the cirrhosis rate. Smith (1981) draws the same conclusion. Two reviews of these relationships worldwide (WHO 1979; Colon 1980) suggest that while alcoholic beverages behave as other market commodities do (in that consumption is affected by price), there are also complicated interactions between the availability of alcohol supplied by the distribution network and the pricing of alcohol.

Cook and Tauchen (1981) also note that the Federal tax on alcoholic beverages has remained constant in nominal terms since 1951. Thus, the real price of alcoholic beverage has actually declined in recent years, such that between 1960 and 1980 the real price of liquor declined 48 percent, beer 27 percent, and wine 20 percent.

Turtle Mountain Community College

P.O. BOX 340
BELCOURT, NORTH DAKOTA 58316
TELEPHONE (701) 477-5605

VOCATIONAL DEPARTMENT

January 7, 1985

To whom this may concern:

This report covers a period from July 1, 1982 to present time.

The Turtle Mountain Community College segment of the Turtle Mountain Youth Alcohol Education/Prevention Program has completed the following as proposed.

	1982	1983	1984	1985
**Students enrolled in the course, 205 Alcohol and Drug Abuse	14	12	18	21
Students enrolled in the course, 206 Alcohol and Drug Dependency	10	12	9	22
Students enrolled in the course, 207 Alcohol and the Family	17	10	9	-0*

* Offered in the Spring Quarter

All courses continue as a part of the Social Science Department, each is offered for three credit hours.

In addition the above courses are being considered for incorporation into a the new Human Services Major, which is being considered for implementation into the offerings of Turtle Mountain Community College. Also, this course material is required for students who wish to pursue a career in the Addiction Counselor field. Turtle Mountain Community College is in contact with the Mary College, Heartview, Southwest Mental Health arrangement, a one year program currently offered. There is student interest in this arrangement.

FETAL ALCOHOL SYNDROME EDUCATION:

The individual consultant, from Turtle Mountain Community College continues to offer the 75 minute Fetal Alcohol Syndrome presentations to:

	1982	1983	1984	1985
Grades 7 to 12	782	521	394	-0-
College students	98	101	96	-0-
Parent Groups	103	154	164	-0-
Teachers	76	88	92	-0-

** The Turtle Mountain Youth Alcohol Prevention/Education Program assists these courses by providing Library materials, films, and offering the students an opportunity to take part in the local activities. The program does not provide any firm funding to the Turtle Mountain Community College operating budget.

The presentation consists of;

Introduction

Slide presentation (Conception to Birth) which clearly defines the importance of the human body formation and growth before birth, this prepares the audience with an understanding of how alcohol and other substances can and will interrupt the delicate development of the human.

Discussion of the above

Movie, Fetal Alcohol Syndrome (This movie depicts how the University of Washington, one of the pioneers in identifying the condition, FAS, became involved, their findings, and shows some of the children they have worked with)

Discussion of the above

Slide presentation of some Fetal Alcohol Children.

Question and Answers.

In addition to the two major areas, the Community College remains active in assisting the Youth Alcohol Prevention/Education Program, in planning activites such as the annual Alcohol Drug Fair, working with schools in their Alcohol Awareness activities, committee groups to sponsor Alcohol/Drug information, a new project will be 30 second radio spots, to run throughout the year.

EVALUATION

The Turtle Mountain Youth Alcohol Prevention/Education Program, comparatively young (3 years plus) has had it's impact on the Turtle Mountain Reservation area. However, three years by comparison is relatively a drop in the bucket, when a lifetime of alcohol permissive, and alcohol ingorance has preceeded this program. In this writers estimation, at last we have a program that is indeed visible, and viable, I strongly recommend that the Legislative Powers of North Dakota, consider this program to continue as is. I would also like to take this opportunity to congratulate the Legislature of North Dakota, for having funded this program, and making all of the education possible, many other states have not even thought about such programs. You all deserve to take credit for the numbers of young people reached through this program, which I promise will make a difference in the quality of Indian life.

Unofficial Statement of
The United Tribes For Reservation Youth Committee, Inc.
(previously known as The Aberdeen Area Committee For Youth)

My name is Roger Trudell, Treasurer of the Santee Sioux Tribe of Nebraska. I also serve as the Tribe's representative to the Board of Directors of the United Tribes For Reservation Youth Committee, Inc., formerly known as the Aberdeen Area Committee For Youth. I am pleased to have this opportunity to address this Subcommittee in connection with H.R. 1156, and I thank you for providing me with this opportunity.

This critique of H.R. 1156 reflects the comments and input of several members of the United Tribes For Reservation Youth Committee, Inc. It has not, as yet, been formally adopted by the committee, however.

Before addressing the substantive provisions of the bill, I would note that we believe that the term youth should be substituted for juvenile throughout the bill. The term juvenile has a negative connotation which should be avoided.

In terms of the substantive provisions of the bill, we generally believe that the bill needs to be altered to take the decision-making authority out of the hand of the federal bureaucracy and put it into the hands of the tribes. Title I, in our view, would entrench a federal bureaucracy that is already failing to adequately consult with tribes in many instances. This bureaucracy would be likely to eat up funds that would be better spent directly on services.

Statement - 1

We believe that it is worthwhile for the B.I.A. and I.H.S. to identify those resources and facilities that are currently available for programs for youth and that can be used as treatment centers. Once they have done so, however, all Indian tribes should receive a report on the available resources and programs to combat alcohol and drug abuse that have been identified. At that point, each Indian tribe should have the option of preparing its own remedial plan, with B.I.A. and I.H.S. assistance should a tribe so request. These plans would be prepared on a local basis for each Indian reservation (and Indian lands near the reservation). These plans would presumably include many of the programs enumerated in the remaining sections of this bill, but might also include programs which address some of the problems underlying the alcohol and drug problem. For instance, some reservations may believe that programs utilizing traditional Indian values and traditions are a high priority; others may believe that providing recreational activities for Indian youths, perhaps by the hiring of youth activities counselors, would be most beneficial -- more so, on some smaller reservations such as my own, then would a residential treatment center. These plans would attempt to specify the estimated population in need and the personnel and physical plant need to put the program in place, as well as the cost of such services (what and how much is presently available and what additional resources are needed), and who would best be able to run the program (the tribe, Federal government, State government, etc.). Indian tribes might propose cooperative programs serving more than one reservation if they believed this to be cost-effective. This approach would assure that programs that are developed will meet specific needs of tribes.

Statement - 2

This is not to say that some of the specific program suggestions in this bill are not worthwhile and should not be included in this bill. For instance, the requirement that B.I.A. and contract schools provide alcohol and drug abuse curricula for grades K - 12 is an important initiative in addressing the Indian youth alcohol and drug problem on reservations. We would suggest that this section be amended to require that schools receiving aid under the Indian Education Act provide adequate drug and alcohol abuse curricula for all of the grades which they serve as a condition of receiving such aid.

We also believe that the requirement that the Secretary of the Interior establish summer recreation and counselling programs for youth on reservations is excellent. The lack of recreational activities for youth, especially during the summer, is a major cause of the substance abuse problem on our reservations. We would not leave decisions as to the opening of B.I.A. and contract schools completely to the Secretary's discretion, however. There should be a requirement that at least one facility per reservation, or on the larger reservations, a facility for each major part of the reservation, be kept open during the summer.

Title III of the bill which provides for training programs for a variety of individuals should be substantially changed. We believe that development of training materials is a good idea. We also believe that there are some categories of individuals who clearly require training, specifically, community health representatives, certain categories of school personnel, and law enforcement officials (section 401) -- in the latter case, tribal officers should be included in the training programs as well as B.I.A. personnel. Aside from these limited categories, however, there should be no mandatory training.

requirement in the bill. Given the limited funds available, many tribes would prefer to use these funds to train a limited number of full-time counselors, rather than use the money to train a variety of individuals with little day to day contact with juveniles. This section of the bill should be amended to allow tribes flexibility in using training funds so that they can decide who is most in need of such training.

The underlying philosophy of Title IV of the bill, to provide alternate placements for youths, is welcome and we support this section of the bill with some amendments. First, the Title should be amended to make it clear that return of a child to his/her family should be considered as an option before incarceration. In addition, placement in a group home should be included as an alternative placement for youths. The bill should also be amended to provide that the tribes, not B.I.A., shall draft regulations for and license emergency shelters, with B.I.A. assistance in developing standards if requested. Conditions vary greatly from reservation to reservation and uniform national standards are likely to be counterproductive, as well as contrary to tribal self-determination. The B.I.A. could draft "back-up" standards should some tribes fail to pass their own standards.

The general purpose of Title V, to provide comprehensive alcohol and drug treatment services, including detoxification, counselling and follow-up care on reservations is, once again, laudatory. This section requires more tribal input than is presently included in this bill, however. I.H.S. should be directed to work jointly with the tribes to develop, on an Area by Area basis, plans to provide adequate residental treatment centers. A nationwide summary could be devised from these Area plans, with further tribal input at that stage before presentation to Congress. It is important for tribes to be involved in this process. Tribes differ greatly in their needs and philosophies in terms of such facilities. Some believe strongly that no child should be sent off the reservation for treatment, others would welcome regional facilities. Only by a localized process with extensive tribal input will this program accurately reflect the needs and desires of the tribes.

Finally, we believe that a section should be added to this bill providing that an Indian tribe may contract to provide any program developed under this Act pursuant to the standards of Public Law 93-638.

We hope that you will accept our comments in the constructive spirit in which they have been offered. We are happy that this committee is focusing upon this most serious problem of substance abuse on reservations and we believe that the current bill provides a strong foundation upon which to build in developing an excellent and worthwhile piece of legislation which will start to address the problem of alcohol and drug abuse among Indian youths. Thank you for providing me with the opportunity to appear before you.

WINNEBAGO TRIBAL CHILDREN'S COURT
P.O. Box 626 Winnebago, Nebraska 68071 Phone (402) 878-2570

WE THANK YOU FOR THIS OPPORTUNITY TO PRESENT TESTIMONY TODAY. I'M JEAN BELILLE AND I AM THE CHIEF JUDGE IN THE WINNEBAGO TRIBAL CHILDREN'S COURT IN WINNEBAGO. I AM REPRESENTING THE WINNEBAGO TRIBE. THE WINNEBAGO TRIBE OF NEBRASKA IS A RECOGNIZED TRIBE ORGANIZED UNDER A CONSTITUTION AND BYLAWS RATIFIED BY THE TRIBE ON FEBRUARY 29,1936 AND APPROVED BY THE SECRETARY OF THE INTERIOR ON APRIL 3,1936. ON APRIL 9,1982, THE SECRETARY OF THE INTERIOR OFFICIALLY APPROVED THE WINNEBAGO TRIBE'S PETITION FOR REASSUMPTION OF JURISDICTION UNDER THE INDIAN CHILD WELFARE ACT.THE EFFECTIVE DATE OF THE PETITION WAS JUNE 21,1982. SINCE THAT DATE, THE COURT HAS HEARD NEARLY 300 CASES ON THE RESERVATION AS WELL AS SEVERAL OUT OF STATE TRANSFER CASES. THE OUT OF TRIBE CASES THAT WE HAVE HEARD COME FROM VARIOUS PLACES INCLUDING WASHINGTON, MINNESOTA, WISCONSIN, KANSAS, CALIFORNIA ,MICHIGAN, AS WELL AS NEBRASKA. OF THE 300 CASES THAT WE HAVE HEARD 125 WERE NEGLECT CASES, 46 WERE LEGAL CUSTODY CASES, 23 WERE CHILD IN OF SUPERVISION CASES AND 72 WERE TRUANCY CASES. THE REST OF THE CASES HEARD INCLUDE TERMINATION OF PARENTAL RIGHTS, CONTEMPT, GUARDIANSHIP AGREEMENTS AND SEXUAL ABUSE CASES. SINCE THE BEGINNING OF THE COURT, WE HAVE SERVED 214 CHILDREN, 167 PARENTS AND 59

EXTENDED FAMILY MEMBERS. OF THESE TOTAL STATISTICS APPROXIMATELY 90 PERCENT OF OUR CASE LOAD IS DUE TO THE USE AND ABUSE OF ALCOHOL. WE ARE HERE TO URGE THE PASSAGE OF H.R. 1156 THE INDIAN YOUTH ALCOHOL AND DRUG ABUSE PREVENTION ACT. MANY OF THE CASES MENTIONED ABOVE INVOLVED JUVENILE PARENTS WHO HAVE PROBLEMS WITH THE USE OF ALCOHOL AND DRUGS. ALL OF THE CHILD IN NEED OF SUPERVISION CASES THAT WE HAVE HEARD INVOLVE TEENAGE CHILDREN WHO ARE HEAVILY INTO THE USE OF ALCOHOL AND OR DRUGS. THE ALCOHOL TREATMENT FACILITIES THAT WE NOW HAVE ON THE RESERVATION ARE DESIGNED FOR THE ADULT ALCOHOLIC. OUR YOUTH ARE NOT BEING SERVED ADEQUATELY. WE HAVE ALL SEEN THE CYCLE THAT ALCOHOL CAN PRODUCE AND ITS TIME WE TRY TO END THE CYCLE. PREVENTION, IDENTIFICATION, AND TREATMENT ARE THE ONLY TOOLS THAT WE HAVE AT OUR DISPOSAL AT THIS TIME. LETS MAKE THEM AS WELL PLANNED AND COORDINATED AS WE POSSIBLE CAN. THIS BILL IS A STEP IN THAT DIRECTION. AS FAR AS THE LANGUAGE OF THE BILL GOES WE WOULD LIKE TO URGE THE FOLLOWING CHANGES: SEC.301 (b) (2), PART (H), IN ADDITION TO TRIBAL COURT JUDGES, TRIBAL COURT STAFF SHOULD ALSO BE INCLUDED .IN SECTION 402 (C)(2) PART (A), THE TRIBAL COUNCIL SHOULD BE ALLOWED TO APPOINT A DESIGNEE TO APPROVE SUCH SHELTERS. THE ONLY OTHER AMENDMENT WE WOULD URGE WOULD BE AN INCREASE IN THE APPROPRIATION TO INCLUDE THE COST OF EMERGENCY GROUP SHELTERS. IN CLOSING AGAIN I WOULD LIKE TO URGE THE PASSAGE OF H.R. 1156 THE INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION ACT. OUR YOUTH ARE OUR FUTURE LETS MAKE OUR FUTURE BETTER.

Testimony of Caleb Shields

Hearing before the

House Committee on Interior and Insular Affairs

May 28, 1985

Rapid City, South Dakota

Mr. Chairman and Members of the Committee: My name is Caleb Shields. I am a member and past Chairman of the the Montana Inter-Tribal Policy Board. I am also a member of the Tribal Executive Board of the Assiniboine and Sioux Tribes of the Fort Peck Reservation, Montana. I am pleased to have the opportunity to present the views of the Montana Inter-Tribal Policy Board on H.R. 1156, a bill to combat drug and alcohol abuse among Indian youth.

As the members of this Committee are well aware, drug and alcohol abuse among our young people is one of the most difficult problems facing Indian tribes today. Alcohol and drugs create severe behavioral problems for our young people at home and at school. As a result, truancy and performance below grade level are common, and many students drop out altogether. In addition, alcohol and drugs have created a crisis in law enforcement. On my Reservation - Fort Peck - alone, over 1,000 young people were arrested in 1984, and we estimate that alcohol, drugs, or both were involved in over 90 percent of these offenses.

The sad fact is that many Indian young people have developed such severe problems with alcohol and drugs before they reach age 18 that they have virtually lost their chance to become stable and productive citizens. Our children are our most valuable resource, and every day we see more of this resource go to waste.

Title II, Education, and Title III, Family and Social Services

In presenting the Board's views on the bill, I would first like to express our support for two provisions in H.R. 1156 that are different from those in H.R. 6196, a similar bill that was introduced at the end of the 98th Congress. First, we support Section 205(a) of the bill, which would require the Secretary of the Interior to establish summer recreation and counseling programs for Indian youth. In the past, several Montana tribes have been able to establish small summer programs for the children on their reservations. These programs are both effective and relatively inexpensive. The Board is pleased that the bill would provide funds for these programs, which would be of particular benefit to tribes with limited resources.

However, we do suggest that either the bill or the Committee report make clear that operation of summer programs could be contracted to tribes under P.L. 93-638. Tribes are certainly the best acquainted with the particular needs of their young people. Also, the experience in Montana, and no doubt in other states as well, demonstrates that tribes are capable of operating excellent programs.

Second, we would like to express support for Section 301(b)(2) of the bill, which would make IHS training on drug and alcohol abuse available to a wide range of concerned individuals, including any interested member of the Indian community. The Board believes that the most effective education of our young people about drug and alcohol abuse must come from concerned members of our local Indian communities. Also, we are certain that many community members would take advantage of IHS training if it were available.

We would now like to suggest two amendments to Titles II and III of the bill.

The first amendment concerns Section 204, which would presently require BIA and contract schools to provide instruction on drug and alcohol abuse to students in kindergarten and grades 1 through 12. While this would be very beneficial to students at these schools, we would like to remind the Committee that many of the schools on Montana reservations - indeed all schools on our Reservation - are ordinary public schools, not BIA or contract schools.

State public schools do, however, receive substantial federal funds due to their high Indian enrollment, including from the Indian Elementary and Secondary School Assistance Act and from the Johnson-O'Malley Act. H.R. 1156 should require these schools, as a condition of receipt of federal funds on behalf of Indian students, to educate these students on the dangers of drug and alcohol abuse. For example, the bill could amend Section 305 of the Indian Elementary and Secondary School Assistance Act and Section 202 of the Johnson-O'Malley Act to impose this condition on receipt of funds under these Acts. I have attached a copy of draft amendments. This should not deter local education agencies from applying for funds under these Acts, because provision of drug and alcohol instruction would be relatively inexpensive, and would also be of great benefit to the students and the surrounding community.

The second amendment concerns Title III. The primary purpose of Title III is to provide education concerning the dangers of drug and alcohol abuse to adults who are in a position to assist Indian young people. As I have already discussed, the Board supports this approach. However, we must also recognize that many of our young people have such serious problems with drug and alcohol that they can only be assisted by counselors who have received much more intensive training than IHS will be able to provide under Section 301(b). At Fort Peck, we regard trained counselors as our single greatest need. The counselors could work not only with our young people, but also with their families. The counselors could provide treatment to young people who are being treated for their problems on an inpatient basis, and could then provide followup counseling once they are released. They could also provide outpatient counseling to children who do not need detention, and assist the schools with their education efforts. We strongly urge the Committee to amend the bill to authorize funds for additional trained counselors.

Title IV, Law Enforcement

We have several concerns about Title IV of the bill, which concerns law enforcement. We agree that many of the juveniles arrested on reservations in Montana for problems related to drug and alcohol abuse would be better off in the emergency shelters authorized by Section 402 than in jail. However, particularly in light of the fact that many of the young people arrested are released to their parents' custody within several hours, we believe that funding for counselors should be a higher priority than funding for emergency shelters.

We also are very concerned about Section 402(a)(3). This section of the bill would require the Secretary of the Interior, in consultation with the Attorney General, to develop guidelines to determine when an Indian youth arrested for an alcohol- or drug-related offense can permissibly be incarcerated rather than placed in a community-based shelter. Any such guidelines should be a matter for individual tribes, not the Secretary. Tribal governments are in a far better position than the Secretary to develop guidelines that will meet their particular needs. Also, the authority to establish guidelines governing the treatment of our children belongs to us as sovereign governments. Section 402(a)(3) should either be removed from the bill altogether, or should be amended to authorize tribes to obtain 638 contracts to develop guidelines for their reservations.

Section 402(c)(3) would require the Bureau of Indian Affairs to promulgate standards for licensing the emergency shelters authorized by the bill. This section should be amended to make clear that tribes can promulgate their own standards for emergency shelters under 638 contracts, and can also use licensing standards that they have already developed.

Title V, Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation

We also have several comments concerning Title V of the bill. We support Sections 501 and 503 of the bill, which would require IHS to determine what residential treatment facilities are needed for Indian youth with drug and alcohol problems, and to identify existing facilities that could be used as treatment centers. However, we also suggest that Section 501 be amended to require IHS, in making its study of needed treatment facilities, to focus on options that would allow Indian young people to remain near their homes for treatment. This would include expansion of existing facilities and establishment of small treatment centers on a large number of reservations. The study should determine how many young people could be effectively treated in small halfway house-type facilities, as opposed to larger hospital-type facilities.

Title VI, Authorization of Appropriations

Our final comment concerns the funds authorized in Section 603(a) of the bill. Section 603(a) authorizes

$5 million to carry out Titles II, III, and IV of the bill. As we know the Committee is aware, this level of funding will barely scratch the surface of the need for programs to combat drug and alcohol abuse among our young people. While we recognize that in the current Congressional climate it will be most difficult to obtain a realistic level of funding for these programs, we urge the Committee to seek more funds. The Administration must be reminded that these programs save money in the long run, because children with drug and alcohol problems become adults who are dependent on welfare and develop illnesses related to drug and alcohol abuse. This means a high level of federal expenditures over a long period of time. The Board strongly believes that a small investment in effective programs to combat drug and alcohol abuse will more than pay for itself in both financial and human terms.

Thank you again for the opportunity to testify. I would be glad to answer any questions.

DRAFT AMENDMENT TO SECTION 202
OF THE JOHNSON O'MALLEY ACT

Section 202 of the Johnson-O'Malley Act (25 U.S.C. 455) is amended by:

(1) striking the colon after "objectives";

(2) inserting between "objectives" and "*Provided*" the following: "and which indicates that the prospective contractor will furnish, either with funds provided under this subchapter or with other funds, a program of instruction regarding drug and alcohol abuse to students in all grades that it serves:"

DRAFT AMENDMENT TO SECTION 305
OF THE INDIAN ELEMENTARY AND SECONDARY SCHOOL ASSISTANCE ACT

Section 305 of the Indian Elementary and Secondary School Assistance Act (20 U.S.C. 241dd) is amended by:

(1) striking the period at the end of paragraph (b)(3) and inserting in lieu thereof "; and"; and

(2) adding at the end of section (b) the following new paragraph: "(4) indicates that it will furnish, either with funds provided under this subchapter or with other funds, a program of instruction regarding drug and alcohol abuse to students in all grades that it serves."

TESTIMONY OF THE
STANDING ROCK SIOUX TRIBE

before the House Committee on Interior and Insular Affairs

May 28, 1985

Rapid City, South Dakota

The Standing Rock Sioux Tribe appreciates the opportunity to present testimony before this committee concerning H.R. 1156, a bill to combat drug and alcohol abuse among Indian youth.

The Tribe commends this Committee for its efforts to address one of the most troublesome problems facing Indian tribes today. As we stated in our comments on H.R. 6196, a predecessor bill, we regard this bill as an important step in solving the terrible problem of drug and alcohol abuse among our young people. It is, however, only a first step - more federal funds will be needed in order to address the problem in a comprehensive way. Of course, the federal government will save money in the long run, because children with drug and alcohol problems become adults who are dependent on welfare and develop severe illnesses related to drug and alcohol abuse. To survive, these adults will need expensive federal programs over a long period of time, whereas programs to prevent drug and alcohol abuse cost relatively little. An ounce of prevention is truly worth a pound of cure in this situation.

Drug and alcohol abuse is very common among our young people. The causes of this problem at Standing Rock are complex. We lack a strong economic base on our Reservation. As a result, unemployment and dependency on welfare are high; self-esteem is low. Alcohol and drugs provide a convenient escape from what appears to be a hopeless situation. Some of our children are from broken homes, come to feel unwanted and insecure, and then seek to fill the void with alcohol and drugs. Also, abuse of these substances has come to be regarded in some circles as socially acceptable among our young people, who have so few healthy outlets for their energies and talents.

Alcohol and drugs prevent many children from performing well in school. They also cause crime. The Tribal Court estimates that over 60 percent of the juvenile cases that come before it result from alcohol and drug abuse.

At Standing Rock, we simply do not have the resources to deal with these problems. We have only two counselors specializing in drug and alcohol abuse to serve the entire Reservation, both young people and adults. We have no inpatient treatment facilities at all, not even a halfway-house. As a result, we must send children with severe drug and alcohol problems off the Reservation for treatment. We cannot afford the best treatment programs, so the children often end up in programs that offer inadequate treatment. Also, even when the children's condition improves, they do not receive adequate follow-up treatment once they return to the Reservation, and their problems frequently recur. Their problems often arise from situations within the family, and since there has been no family-based counseling, the problems resist solution.

Against this background, we present the following specific comments concerning the bill.

Title II, Education

We would first like to express our support for Section 205(a) of the bill, which would require the Secretary of the Interior to establish summer recreation and counseling programs for Indian youth. In our comments on H.R. 6196, we suggested that a similar provision be added to the bill. Although the funds available to us are very limited, in the past we have been able to establish small summer programs for children on the Reservation, including career workshops and a basketball program. We found these programs to be both effective and inexpensive. With the additional funds that H.R. 1156 would provide, we could expand these programs to reach more children.

However, Section 205(a) should be amended to make clear that operation of summer programs could be contracted to tribes under P.L. 93-638. Our experience demonstrates that tribes are capable of operating excellent programs. Also, we are in a better position than the BIA to select the programs that will best suit our young people.

We would like to renew another suggestion that we made concerning H.R. 6196 that has not yet been incorporated into H.R. 1156. Section 204 of the bill would require BIA and contract schools to provide instruction concerning drug and alcohol abuse to students in kindergarten and grades 1 through 12. This would be very beneficial to students at the BIA schools at Fort Yates, North Dakota, and Little Eagle and Bullhead, South Dakota. However, many of the schools on Standing Rock, in both North and South Dakota, are ordinary public schools, not BIA schools.

These public schools do, however, receive substantial federal funds due to their high Indian enrollment, including from the Indian Elementary and Secondary School Assistance Act. H.R. 1156 should require these schools, as a condition of receipt of these funds, to educate Indian students on the dangers of drug and alcohol abuse. The bill could amend Section 305 of the Indian Elementary and Secondary School Assistance Act to impose this condition on receipt of funds under the Act. This is extremely important, as we regard early education of our children concerning the dangers of drug and alcohol abuse as a crucial step in eliminating this tragic problem from our Reservation.

Title III, Family and social services

Although the bill's primary focus is prevention, it also seeks to assist those young people who have already developed drug and alcohol problems. One method of assistance would be to provide training concerning drug and alcohol abuse to BIA, IHS, and school personnel, as well as to concerned members of the community. The objective is to make certain that those adults who are in a position to influence Indian young people are well informed concerning drug and alcohol abuse.

We agree that this approach would be useful, primarily for those children who are not yet involved with alcohol and drugs or who are still at the "experimentation stage." Unfortunately, however, many of our young people have already developed such serious problems with drug and alcohol that they can only be assisted by professional counselors. As we understand Section 301, the type of training it envisions would not be either lengthy or specialized enough to qualify the adults who receive it to provide professional counseling.

We urge you to amend the bill to authorize funds for additional professional counselors. The counselors we need would work with children and, just as important, with their families, including those referred by the Tribal Court and the schools. They would provide follow-up outpatient counseling for children who have been treated on an inpatient basis. They could also run education programs in the communities and assist the schools with their education programs.

The need here is so great that we must make the effort to obtain more funds, despite federal budget concerns. We believe that a small investment in effective alcohol problems will more than pay for itself by reducing federal health and welfare expenditures on behalf of individuals who receive successful counseling.

Title IV, Law enforcement

We suggest several amendments to Title IV. Section 402 authorizes creation of emergency shelters to be used for Indian juveniles who are apprehended for offenses related to alcohol and drug abuse. Most of the children arrested on the Standing Rock Reservation for offenses related to drug and alcohol are released to the custody of their parents or guardian within two or three hours of their arrest. Therefore, we do not have a strong need for the emergency shelters authorized by Section 402. The money authorized for this purpose would be better spent on providing more counselors so that young offenders can obtain the help they need.

Section 402(a)(3) would require the Secretary of the Interior, in consultation with the Attorney General, to develop guidelines to determine when an Indian youth arrested for an alcohol or drug related offense can be placed in any facility other than an emergency shelter of the type authorized by the bill. Any such guidelines should be a matter for individual tribes, not for the Secretary. As sovereign governments, tribes have the authority to control placement of children that have been arrested on the Reservation. Furthermore, we are concerned that the bill seems to assume that all children who are arrested for a drug or alcohol related offense must be placed in a treatment facility of one kind or another, rather than returned to their parents. We are concerned that the guidelines promulgated by the Attorney General would reflect this assumption.

Section 402(a)(3) should be removed from the bill altogether. In the alternative, it could be amended to simply recommend that tribes develop the guidelines, and authorize tribes to seek 638 grants for this purpose.

Section 402(c)(3) would require the Bureau of Indian Affairs to publish standards for licensing the emergency shelters authorized by the bill. As noted above, we do not regard these shelters as a high priority. However, if they are authorized, the bill should be amended to make clear that tribes can develop their own standards for emergency shelters, or can use licensing standards that they have already developed for foster homes or similar facilities.

Title V, Juvenile alcohol and drug abuse treatment and rehabilitation

We are pleased that the Committee has removed the emphasis on regional treatment centers from Title V. In our comments on H.R. 6196, we had objected to this emphasis, pointing out that sending children away from the Reservation for treatment is undesirable for a number of reasons.

We suggest that Section 501 of the bill be further amended to require IHS, in making its study of needed treatment facilities, to consider options that would allow Indian young people to remain near their homes for treatment. This would include expansion of existing facilities, converting portions of outpatient facilities to inpatient facilities, and establishment of small treatment centers on a large number of reservations.

Thank you for your consideration of our comments.

Respectfully submitted,

STANDING ROCK SIOUX TRIBE

By: Allen White Lightning
Standing Rock Sioux Tribal Council

PRESENTED BY:

JACKIE ROUSE
EVERDALE SONG HAWK
YANKTON SIOUX TRIBE'S
ALCOHOLISM PROGRAM

MEMBERS OF THE COMMITTEE, STAFF MEMBERS, WE ARE HERE REPRESENTING THE YANKTON SIOUX TRIBE AND WISH TO SUBMIT THE FOLLOWING COMMENTS ON HS 1156, THE INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE LEGISLATION, FOR THE RECORD.

FIRST, WE WOULD LIKE TO EXTEND OUR SUPPORT FOR THE EFFORTS OF REPRESENTATIVES BEREUTER, DASCHLE, UDALL, YOUNG AND WILLIAMS WHO INTRODUCED THIS BILL.

We do not see any substantial changes that need to be considered in Sections 101 through 202 under Title I, but would like to see a statement included to say that counseling modalities are to be culturally sensitive and geared to meet the needs of our people.

Title II, Section 204, rather than a generic approach to teaching K-12 about alcohol and drug abuse, there should be language included in this Section that allows for local tribal input in curriculum development. This would enable specific cultural input from individual tribal perspectives, to fit the needs of each Tribe. Section 205 (a)(1), We feel that summer recreation and counseling programs for the youth should be **family focused**. Section 206, we find acceptable as is. Section 301 (b)(1), We feel needs to include State Social and Economic Assistance workers who are working on or near reservations. Sections 401 through 502, we find acceptable as is.

Section 501, Title V, We have for many years experienced our juveniles being "sent" to treatment and while these juveniles are in the treatment environment do fairly well; however, upon returning to their respective communities, find nothing has changed and re-engage in the problem areas for which the were "treated" within two to three weeks. This would clearly suggest that rather than "regionalize" treatment, there must be **family focused programs** that not only strengthen dysfunctional individuals but strenghten dysfunctional families, thus strengthening communities on the reservation.

Treatment Programs must be developed and implemented locally to be effective. Indian tribes in general terms are aggregates of families and it is the strength of families that determine the strength of the tribe. Removing juveniles from their respective communities seems inconsistent with the intent of PL 95-608, the Indian Child Welfare Act. Therefore, this whole section needs to be restructured to enable the development of **family focused** and community focused programs.

We, too, on the Yankton Reservation have problems with vandalism, curfew violations, truancy, breaking and entering, theft, and other criminal activity which is 95% related to alcohol or drug abuse. We see a need for year around **family focused** recreation, **family focused** treatment, and **family focused** community activities. We see a need for more drug and alcohol education and more marriage and parenting education in the public schools serving our Indian Communities. We see that **Family Focused Treatment Centers** must be developed and implemented on reservations to save our youth and preserve our culture and to allow us to grow toward self-preservation and self-determination.

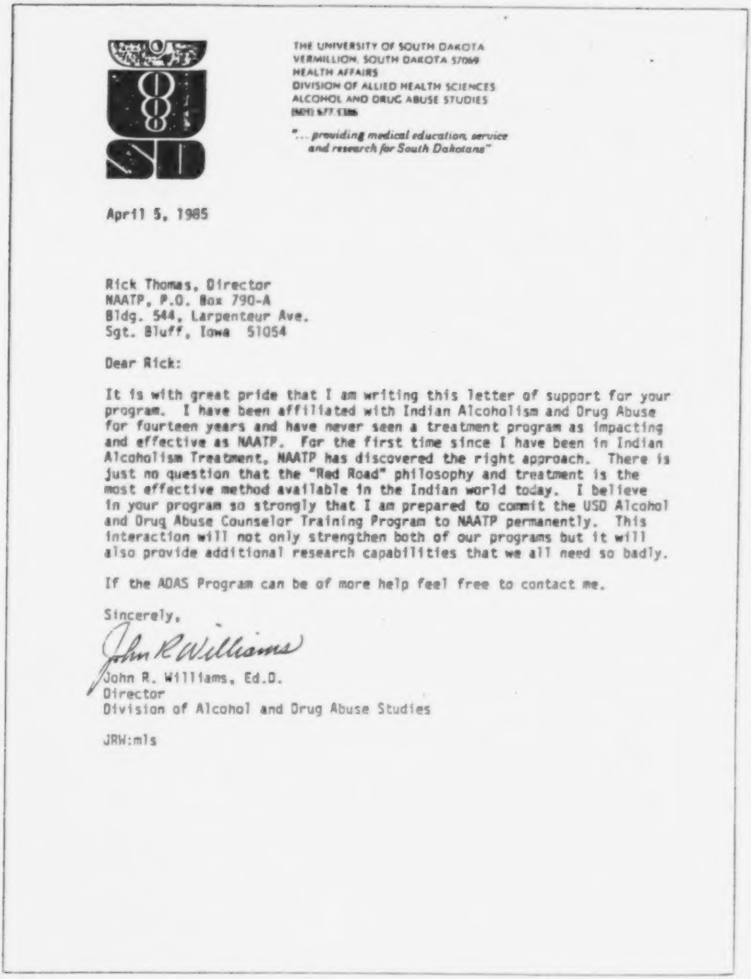
Thank You.

Jackie L. Rousel
Yankton Sioux Tribe
Alcoholism Program

DEVILS LAKE SIOUX TRIBE
FORT TOTTEN, NORTH DAKOTA
PEGGY L. CAVANAUGH C.D.U. DIRECTOR

IN BEHALF OF THE DEVILS LAKE SIOUX TRIBE
RICK THOMAS, DIRECTOR
NATIVE AMERICAN ALCOHOLISM TREATMENT PROGRAM
SARGENT BLUFF IOWA

MY NAME IS PEGGY CAVANAUGH DIRECTOR OF THE CHEMICAL DEPENDENCY PROGRAM, REPRESENTING THE DEVILS LAKE SIOUX TRIBE OF NORTH DAKOTA I BRING GREETINGS FROM OUR TRIBAL CHAIRMAN ELMER WHITE SR. I HAVE WORKED WITH IHS ALCOHOLISM PROGRAMS FOR 5 YEARS, I HAVE SEEN TREATMENT PROGRAMS COME AND GO, I HAVE SEEN CHANGES OF MODALITIES AND TREATMENT APPROACHS PROGRAM TO PROGRAM. TWO MONTHS AGO I EXPERIANCED THROUGH A TREATMENT TRAINING PROGRAM WITH THE NAATP A UNIQUE APPROACH TO TREATMENT OF OUR NATIVE AMERICAN PEOPLE. I FEEL IT IS A TREATMENT THAT BRINGS FINALLY TO OUR PEOPLE TRUE HEALING OF HEART, MIND AND SOUL. THE HOLISTIC TREATMENT APPROACH THROUGH THE RED ROAD PHILOSPHY I FEEL IS ESSENTIAL FOR THE RECOVERY OF OUR PEOPLE AND OUR CHILDREN. IT IS WITH GREAT PRIDE, EXCITEMENT AND RELIEF THAT I WHOLEHEARTEDLY SUPPORT AND RECOMMEND THE RED ROAD APPROACH TO ALCOHOLISM TREATMENT OF THE NATIVE AMERICAN. TO ADDRESS THIS PHILOSOPHY I WOULD LIKE TO INTRODUCE MR. RICK THOMAS, DIRECTOR OF THE NATIVE AMERICAN ALCOHOL TREATMENT PROGRAM, SARGENT BLUFF IOWA.



THE UNIVERSITY OF SOUTH DAKOTA
VERMILLION, SOUTH DAKOTA 57069
HEALTH AFFAIRS
DIVISION OF ALLIED HEALTH SCIENCES
ALCOHOL AND DRUG ABUSE STUDIES
[illegible]

"... providing medical education, service and research for South Dakotans"

April 5, 1985

Rick Thomas, Director
NAATP, P.O. Box 790-A
Bldg. 544, Larpenteur Ave.
Sgt. Bluff, Iowa 51054

Dear Rick:

It is with great pride that I am writing this letter of support for your program. I have been affiliated with Indian Alcoholism and Drug Abuse for fourteen years and have never seen a treatment program as impacting and effective as NAATP. For the first time since I have been in Indian Alcoholism Treatment, NAATP has discovered the right approach. There is just no question that the "Red Road" philosophy and treatment is the most effective method available in the Indian world today. I believe in your program so strongly that I am prepared to commit the USD Alcohol and Drug Abuse Counselor Training Program to NAATP permanently. This interaction will not only strengthen both of our programs but it will also provide additional research capabilities that we all need so badly.

If the ADAS Program can be of more help feel free to contact me.

Sincerely,

John R Williams

John R. Williams, Ed.D.
Director
Division of Alcohol and Drug Abuse Studies

JRW:mls

NAATP is concerned that Alcohol/drug abuse is related to mental health issues that need to be recognized. We have been able to address these issues with the networking in the Woodbury Community, due to problems and issues that are uncovered in our treatment approach.

NAATP TERMINOLOGY:

Psychological Suicide: is evident in all clients entering our facility for services. "Psychological Suicide" meaning that our Indian people have literally destroyed themselves by their own mental perception of self.

Emotional Retardation: Indian people have been emotionally drained due to crucial Human Development in a chemical enviornment. Expressing self and sharing feelings is a phobia, not fears that are extremely imprinted within at the age of 4 to 6 years of age.

Pre-Para-Alcoholic: Recognized in adults up to the age of 50 years old. "Pre-Para Alcoholic" is the negative imprint received as a child, in the target age of 0 to 4 years old. Don't talk/don't feel up bringing that is directed to emotional retardation. Negative reinforcement is recognized due to values, responsibilities, authority figures; and other areas of human growth. They have been deprived of all human needs - such as Love, Compassion, Respect, Warmth, Closeness and more important Trust.

Para-Alcoholic: Is recognized in the target age of 5 - 11 years of age. Where a lot of confusion, anger, resentments are now recognized as Emotional Paint. Emotionally, spiritually and mentally a child will stop growing at this stage of life. Pre-para and Para-Alcoholism is now the people who are currently seeking help through programs within the IHS areas. Education and training are geared toward the primary alcoholic and is totally off base as treatment, prevention and after-care components are concerned.

Where do we fit into society:

When a person grows up in a chemical enviornment, they have no awareness as to who they are, where they are headed, due to physical, sexual and verbal abuse they experience in life. Another form of culture is now evident in our Indian communities. The Identity and Image was lost 40 to 50 years ago, due to the impact of said chemicals. This awareness is now forcusing toward a individual to develope a Philosophy on how they want to live, plus the back bone of a culture is a Belief system and values are acquired from thier belief system which in turn gives people an identity. Treatment modalities must focus in this areaz to take a person back into life to relive what occured such as:

D.E.S.S.-"Delayed Emotional Stress Syndrome". This area is very vital due to healing through feeling. This can be related today to the Viet Nam Vet in the rehavilitation process of war experiences. NAATP related to their early childhood development that has been proven very beneficial.

"Childhood Burn-Out" Both male and female adults have been literally burn-out due to the child/adult reversal. Meaning that the child baby set their younger brother/sisters when parents were out on drinking binges. Childhood up bringing was to baby sit their drunken parents and took up the role as parenting the parents.

The terminology recognized is what the NAATP has developed a purpose and philosophy known as the "RED ROAD APPROACH" healing theough feeling. A wholistic perspective into taking a client beyond sobriety, known as serenity. Treatment modalities is stressed from the Native American point ofview.

HABILITATION PROCESS

Measures of Prevention for each N. A. CHEMICAL DEPENDANT FAMILY development stage

STAGE # 1. Intervention; education; support: with Home intervention

Evolutionary measures are being taken in this field. Yet, it is on the rise within our Race. There needs to be a change of attitude by our People that chemical abuse is not INDIANESS. We need to re-establish what Native American MANHOOD/WOMANHOOD is in order for our children to be aware of what they can become; next, we need to have more "INDIAN ROLE-MODELS" accessable to Indian Youth. We Native Americans are basically affective on eutated and learn through observation than transference to cognative aspects results for a total picture. RESPECT, a virtue/value with our people is a primary prevention measure that is effective when this virture is internalized! Intervention into, education of and constructive support will enhance prevention in this area, Treatment for the Parents: prolonged aftercare services.

STAGE # 2. = Primary Prevention with Home Intervention

Affection; loving; reinforcement; affective education; positive role-modeling; respect: human touch; Primary prevention measures; balance. Treatment for parents - prolonged aftercare follow-up support services.

STAGE # 3. = Primary prevention measures with home intervention

Stage 1 & 2 measures with cognative education of wellness; chemical education as an integral part of total education; basic human development skills: affective stressed for positive start of individual measures; TX for parents and prolonged aftercare - follow-up; support services.

STAGE # 4. = Secondary prevention measures with home intervention

Stage 1, 2, & 3 measures with cognative data increased; affective process based upon "group-process" for positive identification, wellness enhancement and support; one to one process for individual enhancement; Philosophy of environment based upon wellness and positive identity enhancement; intensive therapy-child may need treatment; treatment for parents; prolonged aftercare; support services; family interaction therapy setting needed:; RED ROAD PHILOSOPY CURRICULUM/PROGRAM.

STAGE # 5. = TeritaryPrevention Measures with home intervention

Stages 1. 2, 3, 4, and 5 measures; cognative level increased; affective process based upon "group--process" with emphasis upon intensive counseling/therapy; extreme sexual issues abuse, dictate professional intensive servicing needed; intensive professional environment is needed; tx strongly recommended; tx for parents is a must! Prolonged aftercare; support services: family interaction necessary; Red Road Philosophy curriculum/program.

STAGE # 6. - Teritary Prevention Measures with Home Intervention

- Stages 1, 2, 3. 4. & 5 measures; cognative education intregal part of total curriculum; affective education essential: wellness concept primary importance; intensive one to one therapy; Group-Process vital; Treatment necessity; sexual issues, cultural issues, lifes issues over burdening; suicide attempts (2) on the average; Treatment for parents a must! Prolonged aftercare and support services essential; family interaction essential. Healing Through Feeling. Feeling through Healing; Youth Treatment (concept) Program.

STAGE # 7. - Teritary Prevention Measure - Treatment with aftercare services

Stages 1.2,3.4.5. & 6 measures; affective education primary cognative data (alcohol/drug) secondary; wellness concept essential; "Healing through Feeling" concept-Red Road Philosophy: Treatment; Prolonged aftercare-support services; community education;

There needs to exists a pay off system for soberiety; A need for soberiety to have meaning in Tribal Business: Community business Affairs and Honor and recognition as a ROLE MODEL; We should be honoring our sober people at Pow-wows; as employees; and as positive representatives of our Trives! Our Tribal Laws need to be Reflective of this and above all the (Laws) need to be ENFORCED!!!!!

As an entire family becomes sick from alcoholism so does the entire Tribe become sick from the unprofessional conduct of people in authority abusing chemicals. (Parent/Child ----- Council/People.)

NATIVE AMERICAN ALCOHOL TREATMENT PROGRAM

P.O. Box 790-A
Bldg. 544
Larpenteur Ave.
Sgt. Bluff, Ia.
51054

THE MEANING OF "INDIAN MANHOOD/WOMENHOOD"

INDIAN WOMANHOOD:

INDIAN WOMANHOOD is a female person of Indian descent, not an ordinary woman but a special person with special qualities of gentleness, modesty, pride and firm standards. This person has strong beliefs and takes pride in her role as a wife, mother and part of the RED NATION. She has her purpose in life and serves it with dignity.

INDIAN MANHOOD is a male person of Indian descent, also a special person with special qualities. He is a leader of his people and guides them well, he takes pride in his role as provider, protector and teacher to his tribe. He too has strong beliefs and lives them, he is the strength in his family, the warrior of his people, THE RED NATIONS.

THE ABOVE EXAMPLE WAS WRITTEN BY A CLIENT WHO SUCCESSFULLY COMPLETED THE NAATP ON FEB. 15th 1985

TESTIMONY
98TH CONGRESS, 2ND SESSION
H.R. 6196

INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

May 29, 1985

Submitted by:

Basil Brave Heart
Employee Assistance Director
Little Wound School
Kyle, South Dakota
57752

OFFICE OF THE SUPERINTENDENT
LITTLE WOUND SCHOOL
KYLE, SD 57752

PHONE
455-2461
455-2804

Comments and Recommendations H.R. 1156
Submitted by Basil Brave Heart
Little Wound School, Kyle, S.D.

1. Secretary will mandate keeping schools open for summer months to provide alcohol and drug counseling, these schools will inlcude Contract, B.I.A., and other schools which have Indian students.
2. Page 5. to strengthen the Family Program--require parent or guardian to receive alcohol/drug counseling whose child has used chemicals abusively.
3. Require Tribal Council members alcohol/drug training who sit on Health and HEW boards. Offer alcohol/drug training to all other Tribal Council members. This training will prevent alcohol/drug programs to fail. Role modeling is also very important.
4. Certification requirement for alcohol/drug counselors.
5. Emergency shelter - approval by Tribal Council licensing requirements to improve the quality of services.
6. Help tribes plan and construct treatment centers.

Additional comments to testimony.

LITTLE WOUND SCHOOL COMPREHENSIVE CHEMICAL DEPENDENCY PROGRAM:

The Little Wound School Comprehensive Chemical Dependency Program is the most complete in-school program of its kind in the nation. The program is run for Indian children, by an Indian staff and administration. Outside evaluators have determined that, as a result of the program, use as well as abuse of chemical substances by Little Wound students had declined since 1980.

The program is located at Little Wound School in Kyle, South Dakota, on the Pine Ridge Reservation. The reservation is geographically isolated (the nearest town over 5,000 population is one hundred miles away), and governed by the Oglala Sioux Tribe. Little Wound School was one of the first schools in the nation to operate under a direct contract between Indian people and the Federal Government. The school has developed:

*Specialized programming to meet the unique needs of Indian students.

*An intensive system to assure that all students learn basic skills, and

*A number of unique, innovative programs to enhance learning.

NEED FOR THE LITTLE WOUND SCHOOL COMPREHENSIVE CHEMICAL DEPENDENCY PROGRAM:

1) Chemical addiction is the number one health, social, and economic problem on the Reservation.

2) The alcoholism rate on the Pine Ridge Reservation is nine times the nation average.

3) Ninety-seven percent of the families on the Pine Ridge Reservation have alcohol or drug related difficulties. (Nearly every Little Wound School student has suffered because of family addiction).

4) A Colorado University study showed that at least thirty-five percent of all students on the Reservation are regular alcohol and marijuana-users and that nearly every young person has experimented with chemicals of some kind.

5) The Reservation has one of the highest incidents of child abuse and domestic violence in the state and nearly every case is related to substance abuse.

6) Ninety-five percent of all arrests, including those for juvenile offenses, on the Pine Ridge Reservation are directly attributable to alcohol/drug abuse.

7) Forty percent of all deaths on the Pine Ridge Reservation are alcohol-related, according to local hospital reports.

8) The Pine Ridge Reservation suicide rate is estimated at five times the national average. Alcohol or drug abuse contributes to eighty percent of all suicides on the Reservation.

9) Alcohol use contributes to ninety-three percent of all reported accidents on the Pine Ridge Reservation.

10) The student drop-out rate from Reservation schools is estimated at seventy-eight percent. Eighty-four percent of the Little Wound School drop-outs reported difficulties with addiction or the addiction of a family member as a major reason. One result is that only fifty percent of all adults have obtained a twelfth grade education. The average grade level attainment is 8.8 years. There are approximately two thousand young people between the ages of fourteen and eighteen who have dropped out of school and need educational services in order to attain basic literacy.

11) At least forty percent of the households on the Reservation are maintained by a single parent because of death, desertion, or divorce - addiction is a factor in almost every instance.

12) The unemployment rate on the Reservation is estimated to average nine times the nation rate. Of 7,801 individuals who could be employed, only 39.1% are in the labor force (from Bureau of Indian Affairs Statistical Report, 1980) and only three thousand people have stable year-around jobs. (From a Lakota College survey, October, 1981.) The majority of the chronically unemployed are addicted.

13) The county within which the Reservation is located has the lowest per person income in the nation. The average family income on the Reservation is estimated at $2,888.00 annually or $233.00 per month. Since the average family size on the Reservation is 5.4, $43,21 per month is the average amount per individual to meet basic food, shelter, housing, transportation and other needs. However, the actual dollar amount is probably less since it is not uncommon for Reservation households to shelter twelve to fourteen individuals because of their belief in the extended family concept. (Statistics are from a March 6, 1981 statement of the President of the United States from the Oglala Sioux Tribe, Pine Ridge). The cycle of poverty is perpetuated by addiction and vise versa.

THE LITTLE WOUND SCHOOL COMPREHENSIVE CHEMICAL ABUSE PROGRAM:

The Program is integrated into every facet of Little Wound School. Little special funding, other than for salary for a Director and payment for referrals has been used. On this limited basis, the Program has shown phenonemal success:

*Twenty seven percent of the entire school staff has completed off-site chemical dependency treatment as professional training or for personal recovery.

*Identified student chemical abusers (5% of the student body) have received treatment for addiction.

*Sixty three percent of all persons treated have maintained sobriety-a rate well above the national recovery average. Ninety percent attend support groups.

*Every freshmen takes a class about addiction. In addition, all Little Wound classes from kindergarten through the twelfth grade, includes prevention activities as an integral part of the class.

*Seventy-five percent of staff have provided outreach services to potential abusers, including their own families, and other community members.

*A Colorado State University study showed that alcohol/drug use of Little Wound students is lower than at surrounding reservation schools and declined from 1980.

Program Activities:

1) The School Team Approach plans and runs weekly activities within the school and community to prevent chemical abuse. Fifty-four community members, school staff and students volunteer their time. Workshops and seminars are held to educate; activities like "Compliment Day" and other student recognition events are held to raise self-esteem.

2) "Project Charlie", grades K through five and "Ombudsman", grades six through twelve, are two special alcohol/drug prevention curriculum projects that every student experiences. The curriculum raises student self-esteem, increases communications, problem-solving, decision-making, and other life skills, and helps student develop their own identities through Values Clarification.

3) Many students use chemical substances because of lack of alternative activities for the community including cultural events such as pow-wows, Indian ceremonies, and community feeds. The school building is open eighteen hours a day.

4) Coaches and Team Leadership Program. The Little Wound High School Athletic teams have an important role to play in preventing Alcohol/Drug problems and promoting chemical health. The program is designed to help team captains, coaches, and team members to define their roles and expectations as coaches and players, talk to team members about chemical use and abuse, learn how to assist team members in developing techniques to recognize the pressures in Athletic competition, encourage development of positive self-worth among coaches, parents, and team and alternatives for coping with stress.

5) Student Assistance Program:
The Student Assistance Program team counselor will provide support for the student, staff and parent through involvement in a support group and individual counseling.

Intervention and Treatment:

1) Employees and students who exhibit behavioral symptoms of addiction are referred to the Employee Assistance Program. They receive in school counseling or off-site treatment. All teachers have been trained to properly identify and refer students who are experiencing problems because of their own or a family member's addiction. The school's alcohol counseling staff are all chemical-free, well-credentialed, and are Native American. (See attached resumes.)

2) On-going support groups, including Parent Effectiveness Training, Alcoholics Anonymous, Al-Anon, Alateen and Emotions Anonymous are held by students, staff and community.

Future Plans:

The Little Wound School Comprehensive Chemical Dependency Program has accomplished a great deal. Much remains to be done. One of the biggest gaps in the program is that of family services. Many students who receive treatment, have to return to families who have not been treated. Within the next five years, the program plans to provide.:

1) Preventative services to at least six hundred students, their families, and community members - up to two thousand people per year.

2) Diagnosis and intervention, and counseling services to all students, staff, and family referrals identified as having symptoms of addiction or abuse-up to five hundred people per year.

3) Treatment to all students and staff in need - up to two hundred people per year.

4) Follow-up services to all students, staff and family members in need - up to five hundred people per year.

5) Train all new school staff and additional community members to identify and refer people in need of treatment.

6) Intensive student counseling program (6 by 6).

On-going evaluation of the existing program has included yearly administration of the School Climate Survey, the Piers Harris Self-Concept Test, and school-made instruments to measure disruptive student behavior. Results substantiate the positive effects of the Little Wound Chemical Dependency Program and are available on request.

For more information, call Basil Brave Heart, Director, Employee Assistance Program, at 605-455-2461, extension 30; or write Little Wound School, P.O. Box 500, Kyle, South Dakota, 57752.

PRESENTED BY

WEBSTER TWO HAWK

PRESIDENT

ROSEBUD SIOUX TRIBE

ROSEBUD, SOUTH DAKOTA

HR 1156

The introduction of HR 1156, the "Indian Juvenile Alcohol and Drug Abuse Prevention Act" emerges as legislation which may align the forces necessary to combat alcohol and drug problems among Indian youth.

While the bill addresses the key components for affecting the identification, information, and referral, counseling services, training (more specifically, problems of alcohol and drug abuse, crisis intervention and family relations), referral and treatment, it would be dangerous to assume this will rectify the problems which have existed on reservations and urban areas for generations.

If we are to address alcohol and drug problems among Indian youth, we must consider the consequences and events that have led up to and contributed to the problems as they now exist at epidemic proportions.

As history has taught us, attempts at assimilation have resulted in disruption of Indian families, a socio/cultural identity conflict among Indian people in general, and much of this is traceable to the boarding school experience. This lesson in history is somewhat bitterly displayed by today's bill with its emphasis on youth, who often display the much deeper, underlying problems of family disintegration, and social neglect. Alcoholism, generations deep, has run rampant on the reservations and today's youth have merely selected another drug of choice, as evidenced in our drug abuse and inhalant problems we are faced with today. Let us remind ourselves that alcohol is a drug, and alcohol and drugs coexist in the same categories. the names have been changed, but both remain one in the same.

Our young people are attempting to deliver to those concerned a loud and clear message: a breakdown of the family unit exists today within the Indian community, and parenting skills are lacking. While the more noticeable problem cases will arise and be identified, possible referred to treatment, these will be presentative of the tip of the iceberg. Recent studies indicate (COLO) that alcohol and drug problems, once thought to be linked to peer pressure, are more critically linked to family upbringing than to peer pressure. While we cannot overlook peer pressure as a contributing factor in our alcohol and drug problems, let us not lose sight of the strongest and most influential unit for our youth, that of their respective families.

An ultimate goal contained within the bill should include the involvement of the family in rehabilitation as well as preventative measures. A challenge that exists before this committee, those that will be involved in prevention activities, as well as treatment, will be the innovations required to include the family as a prerequisite and necessary component fundamental to this bill's success or failure.

The treatment of adult alcohol and drug problems on the reservation amplifies one primary difference between treatment among the Indian and non-Indian sectors; that of habilitation vs. rehabilitation. Thus, habilitation becomes the conscriptive force to insist upon family involvement.

It would be naive to expect IHA, the schools, courts, and even the community itself to deal with the alcohol and drug problems of today's Indian youth entirely and independently at their respective levels. An all out effort of cooperation will have to exist to facilitate the treatment of alcohol and drug problems as we know them. Alcohol and drug professionals will have to link closely and cooperatively with mental health professionals on the issues of alcohol and drug problems and parenting skills. A trained, enlightened, education, law enforcement, and IHS/BIA staff will be on the "front line" to identify the symptoms, of troubled problem youth in schools, courts, and hospitals and make proper, expedient referrals.

Indian youth represent 40% of the entire Indian population. The alcohol and drug problems among this population has a devasting effect on schools, law enforcement, hospitals, family and society itself. As potential parents themselves, they lack the necessary information and skills to prepare them for parenting. Through the disintegration of family caused by alcohol and drug problems besetting them, their chances of successful parenthood is limited. The challenge before us is to instill proper values and examples that leads to the development for tomorrow's leadership.

Rather than react to this problem, we must join it and attempt to assist in resolving the issues at hand. This bill appears in its spirit in keeping with that. Youth, in this case, may be our teachers, in that they hold the key to highlighting a pre-existing problem. The spirit and intent of this bill allows for addressing the primary causation and continuance of alcohol and drug problems amongst youth, and that is of the family and their responsibility to their off-spring. Due to the denial factors that exist within chemical abuse, the denial becomes family denial. This bill affords the opportunity to break through the denial, often generations deep.

If schools are to be a mechanism, be they BIA or public, through which young Indian people are to be sensitized and informed of the causes and effects of alcohol and drug abuse, then the curriculum, by which such information is to be delivered, must be relevant to representative of the environment in which Indian young people must survive. Too often, the curriculum used to educate Indian students is designed for the average American student. It must be understood that reservations are not "average middle class America". Therefore, any curriculum that is now available and which is designed to teach Indian students in the area of alcohol and drug abuse causes and effects must be thoroughly evaluated to determine sensitivity to the Indian community, insuring that such curriculum realistically addresses the social and cultural parameters within which the Indian student lives and functions. If available curricula is not appropriate, then appropriate curricula must be developed to adequately address the need herein.

In summary, addressing the problem of adolescent alcohol and drug abuse, all of several aspects which relate to the issue must necessarily be included in the process of prevention and treatment. The family, the community, and the school must have maximum sensitivity and the mechanisms to carry out their respective roles in the remedy to adolescent alcohol and drug abuse. All aspects of this relationship must deliver commitment and effort equally in order to increase the chance for success.

Attached are statistics provided by Rosebud Sioux Tribal Police records, and area school expulsion, suspension, and dropout records some of which may be attributed to juvenile chemical abuse.

The Rosebud Sioux Tribe Official Police records, which are kept by the JPO, until 18 yrs. of age has an active file, 366 cases, both male and female, which dates back to 1980- of these 366 cases, 197 are males and 169 are females. In all of the 366 Juvenile cases the juveniles were incarcerated. In going through every case in the males cases there were 42 alcohol or drug related incidents or 21% of total males incarcerated, of the females there were 45 cases that were alcohol and drug related incidents or 27% of the total females incarcerated, or to put it another way it is 24% of the combined total of 366 juvenile cases. These cases are based on the crimes of alcohol, Drugs,(which includes) Huffing (Gas or Paint), Sniffing, Marijuana, LSD, and all DWI cases. In doing the statistics on the number of Juveniles that miss school, suspended, or expelled for the school year 1984-85 for the use of drugs or alcohol.

TODD COUNTY JR. & SR. HIGH

GRADE:	MALE:	FEMALE:	TOTAL Indian STUDENTS	PERCENT:
7th	1	1	100	2%
8th	5	1	90	15%
9th	13	21	116	3.4%
10th	12	10	60	2.7%
11th	7	9	36	2.2%
12th	6	4	46	4.6%
	44	46	448	5%

HE DOG SCHOOL DISTRICT

GRADE:	MALE:	FEMALE:	INDIAN STUDENTS:	PERCENT:
6th	1	2	20	6.5%
7th	3	3	21	3.5%
8th	1	1	12	2%
	5	6	53	4.8%

ST. FRANCIS SCHOOL DISTRICT

Grade:	FEMALE:	MALE:	INDIAN STUDENTS:	PERCENT:
12th	16	19	35	100%
11th	11	12	23	100%
10th	23	17	40	100%
9th	23	22	45	100%
8th	14	15	29	100%
7th	5	5	29	2.9%
6th	0	1	30	1%
	102	91	231	2.3%

WHITE RIVER SCHOOL DISTRICT

Sixth grade through twelfth grade

	Male	Female	Total	Students
6th	1	0	23	1%
7th	4	0	13	3.2%
8th	1	4	16	3.1%
9th	5	2	19	2.7%
10th	6	6	17	1.4%
11th	4	6	22	2.2%
12th	6	2	12	1.5%
	27	20		

Total Indian Students K-12th = 231

LAST SPRING (1984), A GRANT WAS SUBMITTED TO THE REGION FIVE (LATER CHANGED TO THE MIDWEST REGIONAL TRAINING CENTER) OF THE U.S. DEPARTMENT OF EDUCATION IN CHICAGO, ILLINOIS TO GET FUNDING FOR AN ALCOHOL AND DRUG ABUSE EDUCATION PROGRAM. THE PROPOSAL REQUIRED SOME STATISTICS TO DOCUMENT THE NEED FOR THE PROGRAM. THE STANDING ROCK COMMUNITY HIGH SCHOOL WAS SURVEYED AND OF THE 162 SURVEYED (GRADES 7-12) 59.8% ANSWERED THEY DO DRINK ALCOHOLIC BEVERAGES REGULARLY.

THE TRAINING TOOK PLACE IN NOVEMBER OF 1985 AND AN ACTION PLAN WAS DEVELOPED. ONE OF THE TEAM MEMBERS WHO DRAFTED THE PROPOSAL WAS OUR DRIVER EDUCATION INSTRUCTOR, WHO THOUGHT THAT A S.A.D.D. (STUDENTS AGAINST DRUNK DRIVING) CHAPTER COULD BECOME A REALITY IF STUDENTS WERE INTERESTED. WE HAVE ENCLOSED A COPY OF THE HISTORY OF SADD FROM THE S.A.D.D. CHAPTER HANDBOOK TO FAMILARIZE YOURSELVES WITH OUR ORGANIZATION.

OUR S.A.D.D. CHAPTER PUT INFORMATION IN THE NEWSPAPERS TRYING TO ENCOURAGE OTHER CHAPTERS IN OUR AREA. WE VIEWED FILMS ON ALCOHOL EDUCATION AND PLANNED A S.A.D.D. DAY WITH A FILM ASSEMBLY FOR THE ENTIRE SCHOOL. WE ALSO HAD A BOOTH AT THE SCHOOL CARNIVAL TO EXPOSE THE COMMUNITY TO OUR CHAPTER OF S.A.D.D. DURING THE LAST WEEK OF SCHOOL WE POSTED THOUGHOUT THE SCHOOL THE ENCLOSED COPY OF U.S.A.A. ANTI-DRUNK DRIVING WEEK.

IN OCTOBER, MARGARET GATES WAS A STUDENT IN DRIVER EDUCATION. TWO STUDENTS FROM OUR SCHOOL LEFT THE FIRST PERIOD TO GO "JOY RIDING", AN ACCIDENT HAPPENED AND HER BROTHER WAS ONE OF THE VICTIMS. THE DRIVER EDUCATION INSTRUCTOR TOOK THE CLASS TO LOOK AT THE VEHICLE. HE STATED I CAN'T SAY ALCOHOL WAS INVOLVED HERE, BUT MRS. GATES, MOTHER OF THE VICTIM, WAS THERE AND STATED, "I CAN". ENCLOSED IS A COPY OF THE JUVENILE ALCOHOLISM COURT

STATISTICS WHICH SHOWS THE ALCOHOL OR ALCOHOL RELATED INCIDENCES ARE ON THE UPSWING IN THE STANDING ROCK TRIBAL COURT.

WE WOULD LIKE TO TESTIFY TO THE NEED FOR COUNSELING AND SUMMER RECREATION IN H.R. 1156. WE NEED SOME ACTIVITIES TO DEVELOP US SOCIALLY AS WELL AS ACADEMICALLY. PRESENTLY THERE ARE TWO SIX WEEK PROGRAMS, N.D. UPWARD BOUND, FARGO, NORTH DAKOTA AND S.D. UPWARD BOUND, SPEARFISH, SOUTH DAKOTA WHICH INVOLVES THIRTY STUDENTS FROM OUR SCHOOL.

WE NEED YOUR HELP TO CREATE PROGRAMS TO GIVE US ALTERNATIVES TO ALCOHOL AND DRUGS. WE WOULD LIKE TO USE THE REMAINING TIME ALLOWED US TO TESTIFY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE IN REGARD TO THE PROBLEM, OUR WISHES, AND NEEDS. THANK YOU FOR PROVIDING US WITH THIS OPPORTUNITY TO SEE FIRST-HAND HOW THE DEMOCRATIC PROCESS WORKS.

HISTORY OF SADD

WHAT IS SADD?

Students Against Driving Drunk — a name which now has meaning to millions of high school students.

WHERE?

In thousands of high schools in all 50 states and Canada.

WHY?

Because these students have recognized the following SAD FACTS:

- Injury from alcohol-caused crashes is teenagers' No. 1 health problem today.
- Teenagers who drink and drive cause the deaths of themselves and others.
- Teenage passengers show a high death rate starting at age 13.
- The 16-to-24 age group causes 44 percent of night-time fatal alcohol-caused crashes.
- In 1980 more than 7,000 teenagers lost their lives in auto fatalities.
- Most teenagers are totally unaware of these SAD FACTS.
- BUT IF THEY WERE, THEY COULD DO SOMETHING ABOUT IT.

WHAT DOES SADD STAND FOR?

Students Against Driving Drunk — students who have organized for the following reasons:

- To help save their own lives and the lives of others.
- To educate students concerning the problem of drinking and driving, including the laws regarding drinking in their state.
- To develop peer counseling among students about alcohol use.
- To increase public awareness and prevention of this problem everywhere.

HOW, WHERE AND WHEN DID SADD BEGIN?

Mr. Anastas developed the program in September 1981 at Wayland High School, Wayland, Mass., where he was Director of Health Education.

WHAT WAS THE ORIGINAL PROGRAM?

A series of 15 programs in health education for students who would expect to obtain a license to drive a motor vehicle. Programs were focused on the use of alcohol in relation to driving, because Robert Anastas recognized this to be the No. 1 health problem facing teenagers. Speakers were brought in from a variety of professional fields to supplement the program. Lawyers and a judge discussed legal problems. Police officers spoke on enforcement difficulties. Highway safety and alcohol beverage commission officials presented facts and statistics. Medical and insurance problems were given attention. Accident victims and members of Mothers Against Drunk Drivers were invited to tell their stories. A field trip was made to a penal institution to interview convicted offenders. Parents were invited to listen.

HOW DID THE STUDENTS RESPOND?

Statistics suddenly became real. Drinking and driving began to appear as a death threat to them personally and a threat to their generation. They felt this problem was their problem — a challenge to them — and that they should be able to do something about it — to begin exerting positive peer pressure against drinking and driving. They wanted to do something constructive.

SADD BEGINS:

Mr. Anastas organized a group of students. A sophomore student became chairman. They called the group Students Against Driving Drunk. A SADD button using their school colors of orange and black was designed, and the juniors and seniors were invited to join the organization.

Recognizing the need for parent participation and support, Mr. Anastas devised the SADD "Contract For Life" between parent and teenager by which mutual help was promised in difficult social situations. The contract in no way condones underage drinking but has had the serendipitous effect of improving communications between parents and teenagers on other difficult adolescent decisions besides drinking and driving. It also has acted as a guide for individual families in handling this social problem.

As enthusiasm increased, they decided to have a SADD Day at their school, to ask

Governor Edward King of Massachusetts to be honorary chairman of SADD and to invite him to help them launch the program statewide. Governor King accepted.

Their SADD DAY was April 15, 1982. Governor King, numerous parents, state and local officials attended. More than 1,000 balloons with the SADD emblem were released. SADD buttons and T-shirts blossomed everywhere. Students signed pledges which stated:

> "We the undersigned believe in the SADD goal to eliminate the drunk driver and save lives and pledge not to drink and drive, or to let a friend drink and drive. IF WE CAN DREAM IT — IT CAN BE DONE."

HOW DID THE PROGRAM EXPAND?

Students prepared public service announcements for radio and television directed to other schools, saying: "Please help us to realize our dreams of no teenage alcohol-related deaths on our highway." The students produced a special song which was taped and used on local radio stations. All newspapers reported events as they developed. Local radio stations ran news stories and public service announcements. Other media coverage developed.

- Governor King proclaimed May 22, 1982, as SADD Day in Massachusetts, giving SADD statewide recognition. Students in all schools which had responded to the publicity and the appeals of the students to join them went to supermarkets throughout the state, distributing literature, buttons and bumper stickers.
- On May 27th, Mr. Anastas and members of the SADD group went to Boston and along with Governor King and the Commissioner of Highway Safety George Luciano, launched the 101 Day Safety Campaign in Massachusetts, to last from Memorial Day to Labor Day, 1982.
- SADD was launched on a national level in September 1982 when Mr. Anastas was invited to address the Presidential Commission on Drunk Driving. Since then financial support from the public and private sectors has enabled the program to spread to all 50 states and Canada.

WHAT DOES THE SADD SUCCESS THUS FAR SUGGEST?

It suggests that high school students everywhere can take the leadership role in the prevention of their own alcohol-related deaths and injuries from drinking and driving if they are given the necessary information, inspiration and leadership.

Appendix B

USAA ANTI-DRUNK DRIVING WEEK

PUBLIC ADDRESS ANNOUNCEMENTS

MONDAY

This is the first day of the United States Achievement Academy Anti-Drunk Driving Week at May 20-24 1985 S.R.C.H.S. (school) Did you know that alcohol related automobile accidents are the leading cause of death for Americans between the ages of 16-24?

As Graduation time approaches, the life of you or a friend may be saved if you don't drink and drive. Please let's do our part to stop the needless killing.

TUESDAY

Students — did you know that on the average weekend night, 1 out of every 10 drivers is legally intoxicated? Every 23 minutes someone dies because of a drunk driver. Please, let's do our part to stop the needless killing on our highways.

WEDNESDAY

A few years ago, young people were frightened at the thought of going to war in Viet Nam. Within the last decade, 225,000 Americans have died because of drunk drivers — this is 5 times the number of US combat deaths in Viet Nam. As graduation nears, please let's do our part to stop the needless killing on our highways.

THURSDAY

1 out of every 2 Americans will be involved in an alcohol related automobile accident in their lifetime. In the next 12 months, 40,000 teenagers will be injured and 4,000 killed by drunk drivers. As graduation time nears, let's do our part to stop the killing on our highways.

FRIDAY

Drinking beer is no guarantee against drunkenness. The alcoholic content of one can of beer, 5 ounces of wine, and 1½ ounces of 80 proof liquor is almost identical. And neither coffee, a cold shower nor an open window can sober up a drunk driver. Drunk drivers account for 50% of all fatal accidents. As prom and graduation nears, let's do our part to stop the needless killing.

Anti-Drunk Driving Week
An Academy Community Service Project
USAA
Executive Offices
Twenty five seventy Palumbo Drive
Lexington, Kentucky 40509
&
STANDING ROCK COMMUNITY HIGH SCHOOL
SALD CHAPTER

Appendix C

Standing Rock Sioux Tribal Court
Standing Rock Sioux Indian Reservation
SIOUX COUNTY NORTH DAKOTA AND CORSON COUNTY SOUTH DAKOTA
FORT YATES NORTH DAKOTA 58538

May 17, 1985

Honorable Allen White Lighting
Standing Rock Tribal Council
Fort Yates, North Dakota 58538

RE: Juvenile Alcoholism
Court Statistics

Dear Councilman Whitelighting:

Pursuant to request, I herewith submit to you that statistics relative to Juvenile Proceedings had in the Standing Rock Criminal Tribal Court.

YEAR		CRIMINAL PROCEEDINGS	TRAFFIC	ALCOHOL OR ALCOHOL RELATED	VANDALISM PETTY OR INFRACTIONS
1983		113	12	90	11
1984		128	12	108	8
1985	January	6	0	10	2
	February	20	2	10	2
	March	31	2	22	7
	April	13	2	11	0
	May	6	0	5	1

I trust that the foregoing will be of interest and assistance to you.

Sincerely,

Lynn E. Erickson
Chief Judge

A "CONTRACT FOR LIFE"
BETWEEN PARENT AND TEENAGER

THE S.A.D.D. DRINKING DRIVER CONTRACT

TEENAGER

I agree to call you for advice and/or transportation at any hour, from any place if I am ever in a situation where I have had too much to drink or a friend or date who is driving me has had too much to drink.

SIGNATURE

PARENT

I agree to come and get you at any hour, any place, no questions asked and no argument at that time or I will pay for a taxi to bring you home safely. I would expect that we will discuss this issue at a later time.

I agree to seek safe sober transportation home if I am ever in a situation where I have had to much to drink or a friend who is driving me has had too much to drink.

SIGNATURE

DATE

T-E-S-T-I-M-O-N-Y

PRESENTED TO:

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS

My name is Arta Carlow and I am Chairwoman of the Oglala Sioux Tribal Health Authority. I thank the Committee for providing the Health Authority this opportunity to present our brief spoken testimony regarding HR 1156 the Indian Juvenile Alcohol/Drug Prevention Act.

Congress and yourselves are aware of the conditions which characterize American Indian reservations, and alcohol/drug abuse in particular, so I will not elaborate on, or be redundant about those matters today. However, I will elaborate on some key or instrumental points which I hope will merit your attention regarding this most serious problem.

First, your inclusion of the Bureau of Indian Affairs (BIA) to jointly share responsibility in the implementation of HR 1156 is to be congratulated. Too often the BIA attempts to absolve itself of responsibility by saying that a particular problem lies solely with the Indian Health Service (IHS). Your attempts at multi-sectoral application of HR 1156 will give much needed authority and leverage in development of sound chemical dependency programs.

Second, recognition of the fact that prevention at early stages will benefit long range goals with respects to substance abuse is to be lauded. Too often the federal agencies entrusted with fiduciary responsibilities implement Crisis orientated programs only, and give little thought to long range planning and solutions to problems.

Thirdly, we implore Congress to recognize socio-economic factors inherent in substance abuse. As you know, unemployment on the Pine Ridge Reservation currently runs at 90% or greater. Hard data confirming a direct correlation between alcohol/drug abuse and almost zero employment is not readily available, however, it is our belief that without economic incentives to improve the quality of life of the Oglala, little improvement in this drastic and serious problem will result.

Our youth of today, as well as their parents and all adults need the development of an infra-structure to better build their world view, esteem, and pride necessary to overcome this deplorable problem. Therefore, we encourage Congress to provide comprehensive economic stimuli as a foundation in addressing this health problem as well as all associated health risks instead of the application of band-aid treatments.

In closing, I wish to quote from the Surgeon General's Report of 1980.

"The critical influence of adequate income, housing, diet, education, and healthful work places in shaping the health of our people deserves continuing and serious attention. Without adequate resources to solve problems in these areas, the health of vulnerable population groups is at risk.

The Director General of the World Health Organization has said that economic development and health are indivisible. This holds true for the disadvantaged in our population.

Fundamental social and economic improvement is essential to better health for Americans". *

---

* Healthy People, "The Surgeon General's Report on Health Promotion and Disease Prevention," Page 141.

Fourth, we ask for recognition of a greater funding level increase in Emergency Medical Services and Ambulance Services for the Aberdeen Agrea in general and Pine Ridge Reservation specifically. As the number one (1) cause of death and injury on the Reservation are alcohol related motor vehicle accidents, coupled with rurality, isolation, and remoteness, EMS/Ambulance services are in dire need on the Pine Ridge Reservation.

Fifth, we urge increased funding for detoxification facilities for not only our youth, but the general population as well. Previously, the OST/ Health Authority operated a Halfway House which intermittently served as a detox unit, however, this was not funded due to budgetary constraints and could not be supported by the Health Authority on a volunteer basis longer than six (6) months.

Lastly, we encourage your recognition of the low funding priority the Aberdeen Area Indian Health Service receives in comparison to other less populated areas. We have attached national statistics supporting this claim for your benefit. Thank you.

Indian and Alaskan Native Deaths by Cause
Pine Ridge Service Unit - 1982

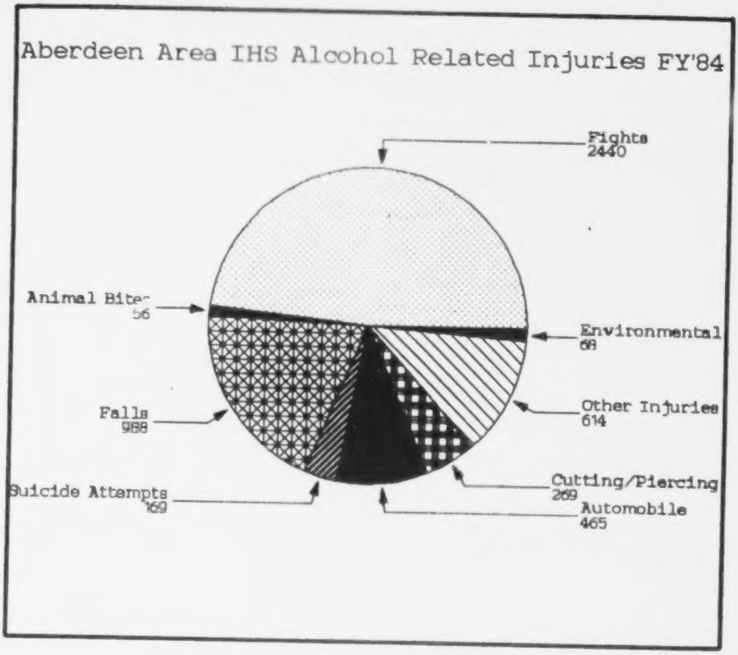
1.	External Causes of Injury and Poisoning	29
2.	Disease of Circulatory System	25
3.	Symptoms, Signs & Ill-defined Conditions	23
4.	Disease of Digestive System	11
5.	Neoplasms	10
6.	Certain Conditions Originating in Perinatal Period	7
7.	Disease of Respiratory System	6
8.	Mental Disorders	4
	Infectious & Parasitic Disease	4
9.	Disease of Nervous System & Sense Organs	2
	Congenital Anomalies	2
10.	Endocrine, Nutritional & Metabolic Disease	1
	Disease of Genitourinary System	1
	TOTAL	125

1982 - PINE RIDGE SERVICE UNIT
MOTOR VEHICLE-ACCIDENTS-SUICIDES-HOMICIDES
DEATHS BY AGE GROUP

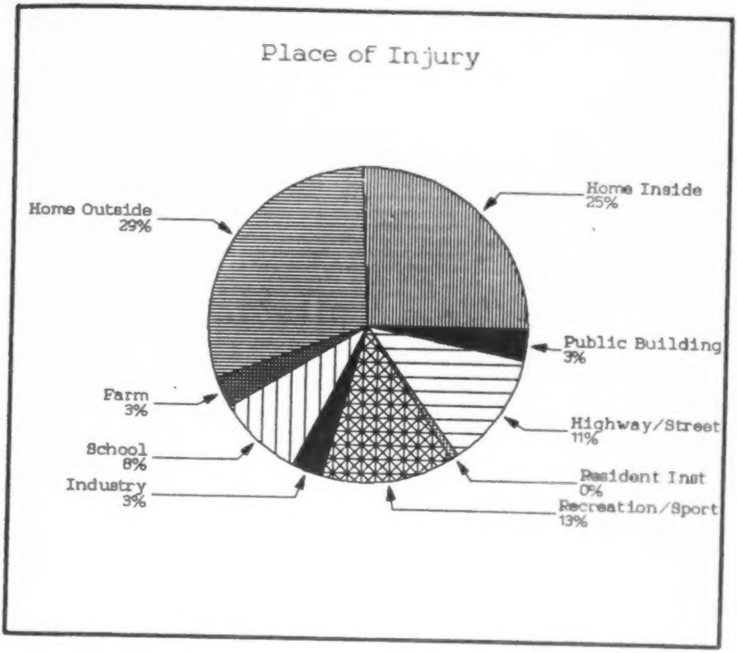
	Total	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65+
Motor Vehicle Accidents									
Collision w/another vehicle	1	0	0	1	0	0	0	0	0
Collision w/pedestrian	2	0	0	0	1	0	1	0	0
Collision w/vehicle/object	1	0	0	0	1	0	0	0	0
Not invol.Coll.on highway	5	0	0	2	2	1	0	0	0
MVA Unspec. nature	1	0	0	0	0	0	0	0	1
Subtotal	10	0	0	3	4	1	1	0	1
Accidents									
Misadvent med care/abnorm react	1	0	0	0	0	0	0	0	1
Acc. caused by fire/flames	1	0	0	0	0	0	1	0	0
Drowning & submersion	1	0	0	1	0	0	0	0	0
Late effect of acc. injury	6	1	0	1	1	0	2	0	1
Subtotal	9	1	0	2	1	0	3	0	2
Suicides									
By other/unspec. firearms	1	0	0	1	0	0	0	0	0
By other means/late effect of self-inflicted injury	1	0	0	1	0	0	0	0	0
Subtotal	2	0	0	2	0	0	0	0	0
Homicides									
Assault-other/unspec. firearms	2	0	0	1	1	0	0	0	0
Assualt-cutting/piercing instr.	2	0	0	1	1	0	0	0	0
Assault-other means/late effect of purposely inflicted injury by another person	3	0	0	1	0	2	0	0	0
Subtotal	7	0	0	3	2	2	0	0	0
Unspecified Injuries									
Injury undeter.if acc/purposely inflicted & late effects	1	0	0	0	0	0	0	0	1
Subtotal	1	0	0	0	0	0	0	0	1
Grand Total	29	1	0	10	7	3	4	0	4

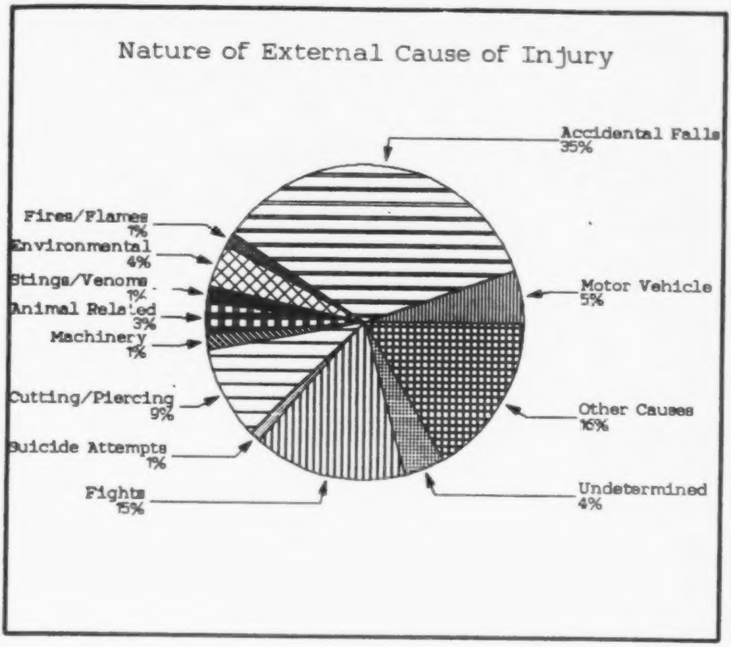
1982 ABERDEEN AREA
DEATHS BY EXTERNAL CAUSE
(Source: Selected Vital Statistics for AAIHS 11/84)

	Aberdeen Area IHS	Cheyenne River	Fort Berthold	Fort Totten	Omaha - Winnebago	Pierre	Pine Ridge	Rapid City	Rosebud	Sisseton-Wahpeton	Standing Rock	Turtle Mountain	Yankton	Sac & Fox
MOTOR VEHICLE														
Collision w/another veh.	15		1	1	1		1		2	3	6			
Collision w/pedestrian	15		1	1			2	2	2	2	2	1	1	1
Collision w/object	2	1					1							
Non-highway collision	15		1			1	5	2	3	1	1	1		
Non-traffice accident	5	1		1				1	1			1		
POISONING														
Accidental drug poisoning	3		1						1		1			
Acc. poisoning other substance	1							1						
Misadvent. Medical care	2						1				1			
FALLS	3					1			1					1
FIRE & FLAMES	7	1		4			1		1					
DROWNING	11		1			1	1	2	4		2			
INHALATION SUFFOCATION														
Food/Object	2										1	1		
ACCIDENTAL FIREARM	2			1					1					
SUICIDE														
Hanging/Strangulation	4	1							2					
Firearm	7	4		1			1			1				1
HOMICIDE														
Assault-Firearm	6	1			1		2			1		1		
Assault-Piercing Object	2						2							
Assault-Other Means	9					1	3	1	2	1	1			
OTHER	27	3		3		5	9	1	3		1	1	1	
GRAND TOTAL	138	12	5	12	2	9	29	10	23	9	16	6	2	3



Aberdeen Area IHS Alcohol Related Injuries FY'84


Place of Injury
Home Outside 29%
Home Inside 25%
Public Building 3%
Highway/Street 11%
Resident Inst 0%
Recreation/Sport 13%
Industry 3%
School 8%
Farm 3%


Nature of External Cause of Injury
Accidental Falls 35%
Motor Vehicle 5%
Other Causes 16%
Undetermined 4%
Fights 15%
Suicide Attempts 1%
Cutting/Piercing 9%
Machinery 1%
Animal Related 3%
Stings/Venoms 1%
Environmental 4%
Fires/Flames 1%

FY '84 Pop. 70,293

NATURE OF EXTERNAL CAUSE OF INJURY
IN RELATION TO ALCOHOL

FOR THE Aberdeen Area SERVICE UNIT

(Figures taken from Ambulatory Patient Care Report)

INJURY	INJURIES FY '84	INCREASE (DECREASE) FROM FY '83	% ALCOHOL RELATED	INCIDENCE RATE/1,000 FY '84
1. Motor Vehicle Accident	1,314	25	36%	19
2. Water Transport	11	(5)	0	0
3. Air Transport	9	1	0	0
4. Accidental Poisoning	208	44	5	3
5. Accidental Falls	8,576	1,308	12	122
6. Fires/Flames	349	66	5	5
7. Environmental Factors	1,087	173	6	15
8. Stings/Venoms	424	(8)	2	6
9. Animal Related	767	78	8	11
10. Drowning/Submersion	28	4	14	0
11. Cutting/Piercing Objects	2,247	209	12	32
12. Firearms Accidents	60	(7)	17	1
13. Machinery	409	34	6	6
14. Suicide Attempts	279	55	61	4
15. Injury Purposely Inflicted by Others	3,723	429	66	53
16. Battered Child	26	6	38	0
17. Undetermined Cause	1,157	227	12	16
18. Other Causes	4,128	259	9	59
TOTAL	24,663	2,898	21%	351
			FY'83	306

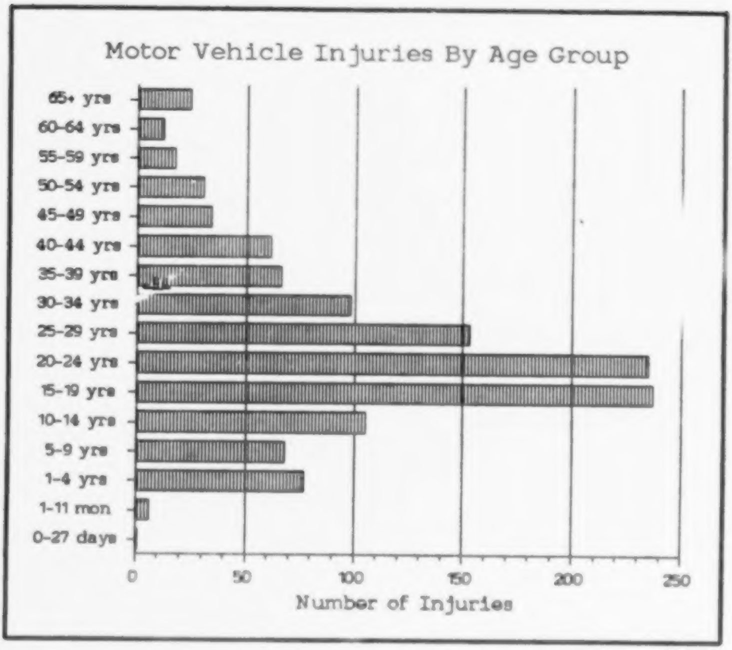
FY '84 Pop. 15,717

NATURE OF EXTERNAL CAUSE OF INJURY IN RELATION TO ALCOHOL

FOR THE Pine Ridge SERVICE UNIT

(Figures taken from Ambulatory Patient Care Report)

INJURY	INJURIES FY '84	INCREASE (DECREASE) FROM FY '83	% ALCOHOL RELATED	INCIDENCE RATE/1,000 FY '84
1. Motor Vehicle	298	112	38%	19
2. Water Transport	2	1	0	0
3. Air Transport	2	2	0	0
4. Accidental Poisoning	43	29	5	3
5. Accidental Falls	1,515	536	13	96
6. Fires/Flames	55	13	9	3
7. Environmental Factors	179	108	7	11
8. Stings/Venoms	59	1	0	4
9. Animal Related	149	36	9	9
10. Drowning/Submersion	5	1	20	0
11. Cutting/Piercing Objects	371	122	16	24
12. Firearms	14	5	21	1
13. Machinery	76	12	12	5
14. Suicide Attempts	61	48	56	4
15. Injury Purposely Inflicted by Others	633	199	73	40
16. Battered Child	3	1	100	0
17. Undetermined Cause	125	(4)	14	8
18. Other Causes	393	(23)	12	25
TOTAL	3,983	1,199	25%	253
			FY'83	182


Motor Vehicle Injuries By Age Group
65+ yrs
60-64 yrs
55-59 yrs
50-54 yrs
45-49 yrs
40-44 yrs
35-39 yrs
30-34 yrs
25-29 yrs
20-24 yrs
15-19 yrs
10-14 yrs
5-9 yrs
1-4 yrs
1-11 mon
0-27 days
0
50
100
150
200
250
Number of Injuries

FISCAL YEAR 1984
DISTRIBUTION OF HOSPITAL AND CLINICS APPROPRIATION
AREA COMPARISON

ABERDEEN AREA INDIAN HEALTH SERVICE
HEALTH SYSTEMS PLANNING

MARCH 1985

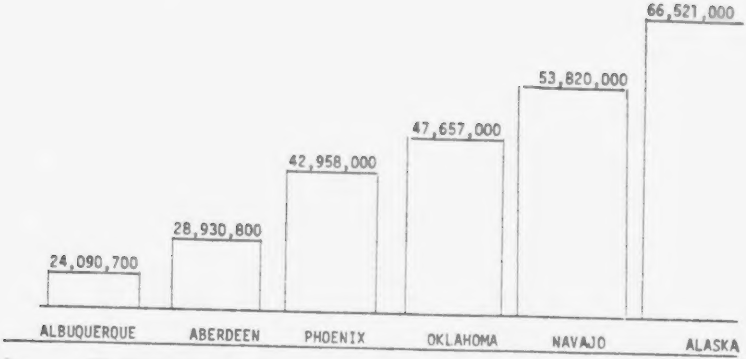
DRAFT

DISTRIBUTION OF HOSPITALS AND CLINICS APPROPRIATIONS
BY AREA AND CLINICAL UNITS
FISCAL YEAR 1984

AREA	ALLOCATION	UNITS 1/	ALLOC/C.U.
ABERDEEN	28,930,800	113,239	255.48
ALASKA	66,521,000	111,814	594.93
ALBUQUERQUE	24,090,700	72,743	331.18
BEMIDJI	17,032,000	23,611	721.36
BILLINGS	16,428,000	57,947	283.50
CALIFORNIA	16,949,000		
NAVAJO	53,820,000	193,494	278.15
OKLAHOMA	47,657,000	144,048	330.84
PHOENIX	42,958,000	145,406	295.44
PORTLAND	10,543,000	35,425	297.62
TUCSON	6,596,000	17,149	384.63
USET	14,912,000	16,479	904.90

1/ Clinical Units = $\frac{\text{Outpatient Visits}}{6}$ + Inpatient Days

FY-84 ALLOCATION 1/



	ALBUQUERQUE	ABERDEEN	PHOENIX	OKLAHOMA	NAVAJO	ALASKA
Per Capita Allocation	470.42	409.50	521.91	250.23	322.21	699.44 2

(AVG. PER CAPITA ALLOWANCE: $445.62)

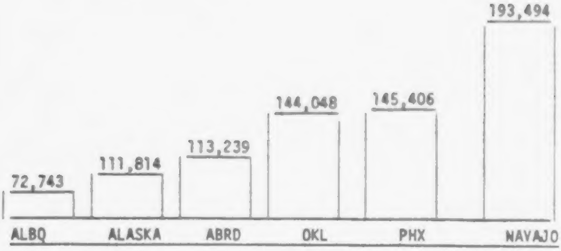
ABERDEEN SVC. POP.:	70,648
AVG. PER CAP. ALLOWANCE:	445.62
	31,482,200
ABERDEEN ALLOW:	28,930,800
DIFFERENCE:	2,551,400

---

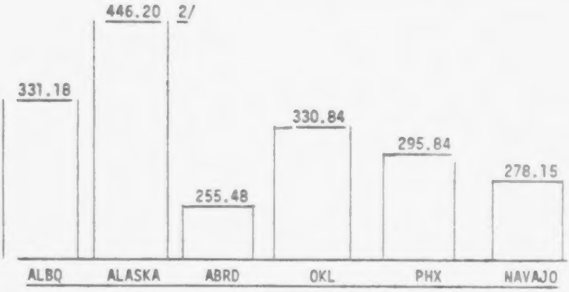
1 / Areas with 200 or more beds available.

2 / Reduced 25% Cost of Living.

FY-84 CLINICAL UNITS 1/



COST PER CLINICAL UNIT PROVIDED



(AVG. COST OF C.U. : $322.88)

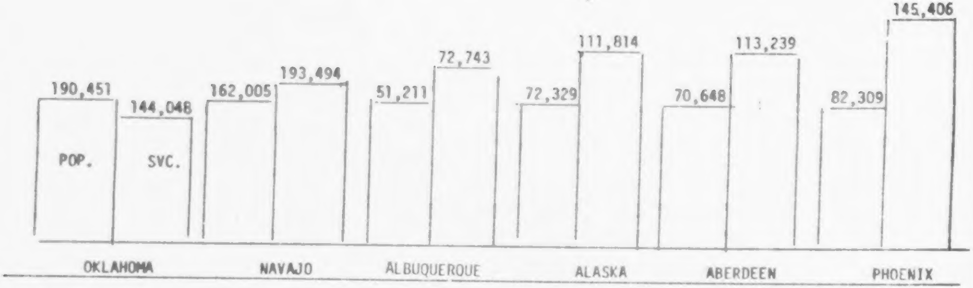
ABERDEEN C.U. =	113,239	PROJECTED C.U.:	120,600 3/
AVG. $ C.U. =	322.88		322.88
	36,562,600		38,939,300
ABERDEEN ALLOW: 84)	28,930,800	85)	30,443,300
			8,496,000

1/ Areas with 200 or More Beds.

2/ Reduced 25% (Cost of Living).

3/ FY-85 Tentative Objectives.

CLINICAL UNITS PROVIDED 1/



C.U. to POP:	0.76	1.19	1.42	1.57	1.60	1.77

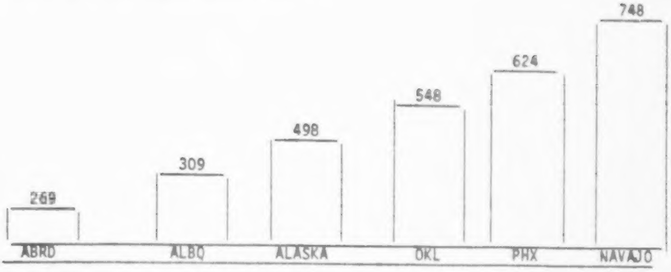
(MEDIAN C.U. TO POP: 1.49)

ABERDEEN PROVIDES C.U. = POPULATION + 60%

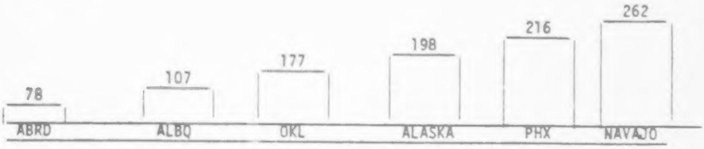
ABERDEEN PROVIDES THIS SERVICE WHILE BEING FUNDED AT THE LOWEST COST PER CLINICAL UNIT.

1/ Areas with 200 or More Beds.

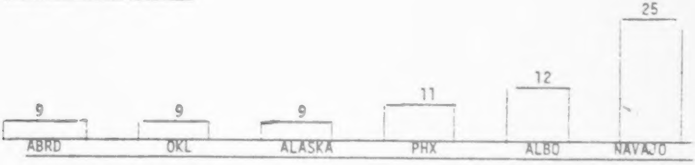
STAFFING OF PRIMARY CARE PERSONNEL 1/



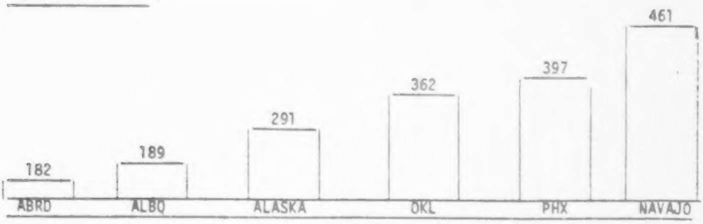
PHYSICIANS



PHYSICIANS ASSISTANTS

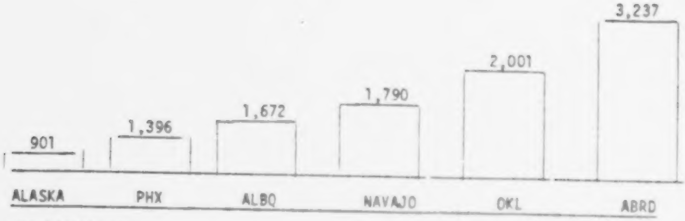


REGISTERED NURSES

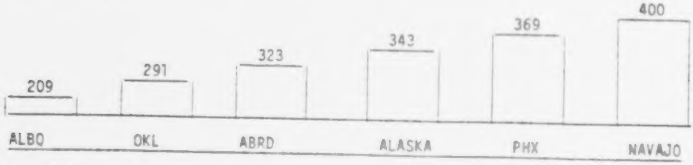


1/ M.D.'s P.A.'s, and R.N.'s

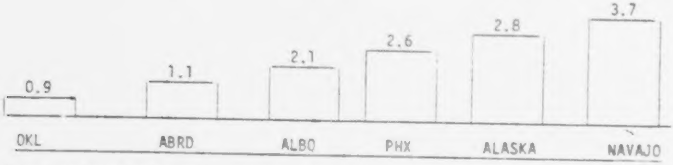
PRIMARY CARE VISITS PER PROVIDER 1/



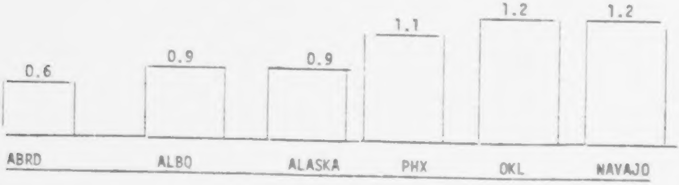
AVAILABLE BEDS



PHYSICIANS PER 1,000



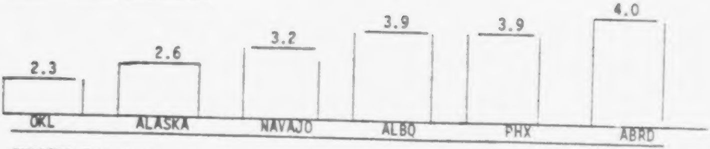
R.N. PER AVAILABLE BEDS



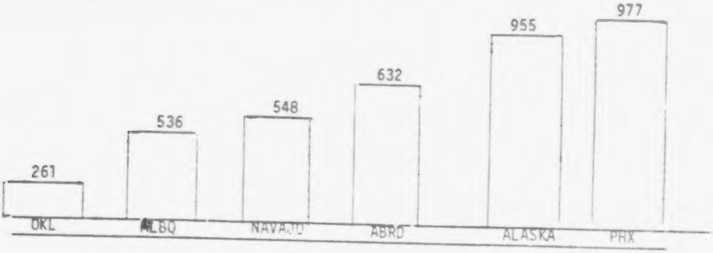
1/ $\frac{\text{PCPV}}{\text{MD + PA}}$ = RATE

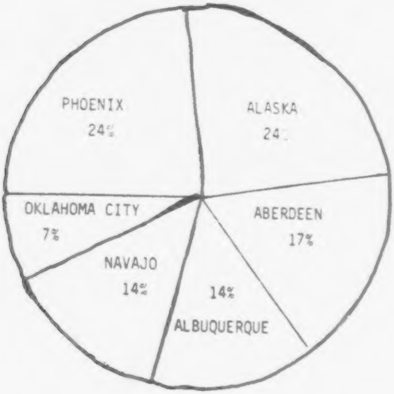
UTILIZATION RATES - FY-1984

AMBULATORY SERVICES 1/



INPATIENT SERVICES 2/

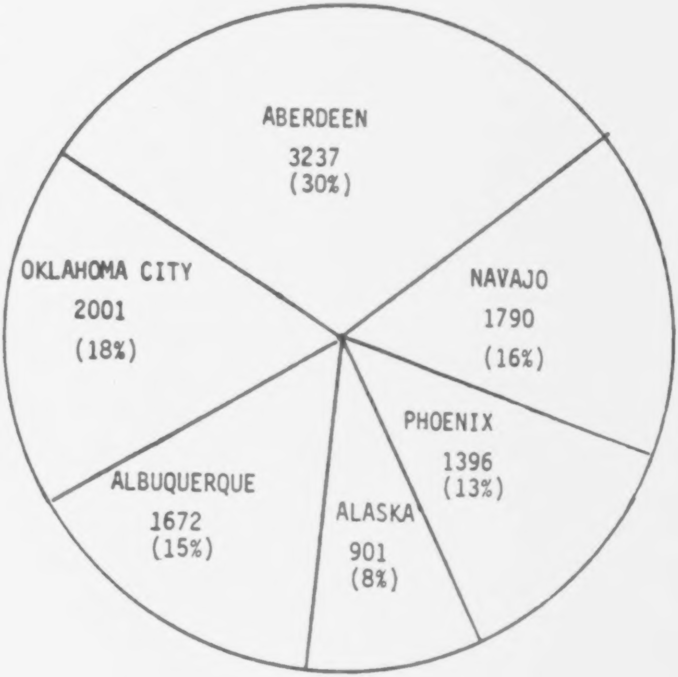




1/ PCP Visits ÷ Population = Ambulatory Util. Rate.

2/ Inpatient Days ÷ Population x 1000 = Inpat. Util. Rate.

WORKLOAD DISTRIBUTION - PRIMARY CARE VISIT PER PROVIDER



AVERAGE VISITS PER PROVIDER: 1833

TESTIMONY OF WALLACE E. COFFEY
BEFORE THE
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
IN SUPPORT OF H.R. 1156
MAY 28, 1985

Mr. Chairman, Members of the Committee:

My name is Wallace E. Coffey. I am the Executive Director of the Nebraska Indian Commission. I am pleased to have this opportunity to appear before you to testify in support of H.R. 1156; further, let me commend each of you for the work you have done in raising these very serious concerns about alcohol and drug abuse among our Indian youth.

The State of Nebraska and the Division of Alcohol and Drug Abuse has financially supported Indian alcohol treatment programs throughout the state. Currently, $498,000 fund eight (8) programs with priority areas being the three Nebraska Indian Reservations, two urban areas of Omaha and Lincoln, and several western Nebraska communities. It is important to note that these programs center around treatment rather than prevention and are principally directed toward the adult instead of the juvenile.

When discussing problems and needs in Indian country and among Indian people we mention unemployment, health care, and law enforcement as the greatest problems or among the greatest needs. We believe that each of these problems are a cause of, or a result of, or exacerbated by drug and alcohol abuse. Many of these conditions are caused by today's Indian juvenile. Therefore, we feel a reduction in incidents of drug and alcohol abuse will make significant improvement in these and, no doubt, other areas.

According to the Caron Institute on Alcoholism and Substance Abuse of Westerly, Pennsylvania, alcoholism is the nation's number one health problem. Statistics provided by the Indian Child Welfare network newsletter indicate: Alcoholism directly or indirectly affects 95% of all Indian families. Rarely is there an Indian family that is not touched by the affects of alcoholism and drug abuse. Many victims today began as very young people. We cannot expect the problem to be solved in a short period. To be effective at all, a commitment must be made for a financially-sustained and well-planned attack. We believe that H.R. 1156 could be a giant step in the right direction.

In recent years, education was a priority among Indian leaders, parents, and government officials. They felt that Indian people, through education, could improve their lives and fill some of the job needs in tribal government programs, making self-determination a reality. Because of their concerns, education became a budget and interest priority and the educational level rose whereby today most tribal government program positions are held by Indian people.

We believe a similar commitment concerning the prevention and treatment of drug and alcohol abuse can meet with similar success. H.R. 1156 speaks to this involvement and commitment in Section 301 where training in the problems

IS TO BE GIVEN OR OFFERED TO THOSE IN LEADERSHIP POSITIONS, OR TO PEOPLE WHO CAN MAKE A DIFFERENCE. THE MORE PEOPLE UNDERSTAND HOW THE PROBLEM AFFECTS THEIR AREA OF RESPONSIBILITY AND HOW THEY CAN COOPERATE IN THE EFFORTS, THE MORE EFFECTIVE IT WILL BE.

H.R. 1156 IS A DRUG AND ALCOHOL PREVENTION ACT. WE MUST ALL REALIZE THAT ALCOHOL PREVENTION WITH EXISTING LITERATURE AND CURRICULUM IS NEW. TRAINING IS SIMILAR BUT DIFFERENT. FOR THIS REASON, WE BELIEVE MOST OF THE EFFORT AND SUFFICIENT FINANCIAL RESOURCES SHOULD BE CHANNELED INTO PREVENTION PROGRAMS WITH SPECIFICITY IN SUCH AREAS AS THE K-12 SCHOOL CURRICULUM, RECREATION PROGRAMS, AND COUNSELING AS MANDATED IN SECTION 204. I HAVE BEEN INFORMED A NUMBER OF ORGANIZATIONS AND/OR INSTITUTIONS WHICH CURRENTLY HAVE CULTURALLY-RELEVANT CURRICULUM WHICH IS DESIGNED TO MEET THE INDIVIDUAL'S CULTURAL AND TRADITIONAL NEEDS. I APPLAUD THEM IN THESE EFFORTS AND RECOMMEND THAT FUNDS BE MADE AVAILABLE FOR INNOVATIVE DEMONSTRATION PROJECTS SUCH AS THESE THAT CAN BE MADE ADAPTABLE TO ALL OF INDIAN COUNTRY AND AT THE SAME TIME REMAIN LOW IN COST, BUT HIGHLY EFFECTIVE.

INITIALLY, THESE PROGRAMS MAY COST AS MUCH TO ADMINISTER AT THE AREA LEVEL AS IS SPENT ON THE PROJECT BUT FOR SMALL TRIBES AND ORGANIZATIONS, INEXPENSIVE PROGRAMS MAY BE AS EFFECTIVE OR MORE SO THAN THOSE THAT TAKE THOUSANDS OF DOLLARS. AND WHEN FUNDING EVENTUALLY "RUNS OUT" IT WOULD BE MUCH EASIER TO SUSTAIN THEIR OWN BUDGETS.

PRESENTLY, THE COST OF HUMAN SUFFERING IS INCALCULABLE. EVERY DOLLAR THAT IS SUCCESSFULLY SPENT ON PREVENTING AN INDIAN YOUNG PERSON FROM ENTERING THE REVOLVING DOORS OF DRUG AND ALCOHOL TREATMENT CENTERS WILL BE RETURNED MANY FOLD IN SAVED HEALTH CARE EXPENSES, LAW ENFORCEMENT AND INCARCERATION COSTS, AND IN ECONOMIC PRODUCTIVITY THROUGH EMPLOYMENT. WE CAN ENVISION HEALTHIER, HAPPIER PEOPLE, MORE STABLE HOMES, AND LESS POVERTY. TO ACCOMPLISH THIS THE EFFORTS MUST BE ADEQUATELY FUNDED. IN A TIME OF BUDGET CUTS AND SCARCE RESOURCES THERE IS A TEMPTATION TO TAP ALREADY STRAINED RESOURCES. A FEW DOLLARS MAY BE FREED THROUGH BETTER MANAGEMENT AND COOPERATION BUT WE BELIEVE THE CURRENT AVAILABLE RESOURCES ARE ALREADY STRETCHED AS FAR AS POSSIBLE. IF THIS BILL IS TO OFFER SOLUTIONS RATHER THAN FALSE HOPE, IT MUST BE FUNDED WITH SOME NEW DOLLARS. WE CAN THINK OF NO BETTER INVESTMENT THAN IN THE FUTURE OF OUR CHILDREN.

THANK YOU FOR LISTENING TO MY COMMENTS.

DATE: May 24, 1985

TO: Honorable Mr. Daschel, Mr. Udall, Mr. Berenter, Mr. Young, Mr. Williams, and Other Invited Guests

FROM: John R. Williams, Ed.D., University of South Dakota

Your efforts in the formulation of H.R. 1156 "The Indian Juvenile Alcohol and Drug Abuse Prevention Act" are to be commended. Before I speak to the content of this bill, may I express a number of concerns relating to Indian Juvenile Alcohol and Drug Abuse.

I am gravely concerned with the time it has taken for the federal sector to recognize the Alcohol and Drug problems of Indian youth. The seriousness of alcohol abuse among Indians was recognized nationally with the passage of the Hughes Act in 1970 that established NIAAA, which in turn designated the "Indian Desk." Additional emphasis was placed on Indian Alcoholism with the transfer of NIAAA funded alcohol programs to IHS in the late 70's. Granted these programs originally focused on adult male Indian alcohol abusers, they have since expanded to include women. Thus for the past 14 years, we have focused our Alcohol and Drug Abuse Treatment efforts primarily on adult Indian Alcohol and Drug Abusers with somewhat limited success. One of the benefits of this effort however, has been to raise the level of awareness regarding the seriousness of drug abuse among Indian youth. H.R. 1156 is a result and certainly a move in the right direction. Should this bill become law, the full range of human drug abuse among Indian people will be recognized and addressed within a span of 14 years. I am impatient and concerned that it has taken so long for a problem of this magnitude to be recognized. Now that it is, let's hope this momentum of concern by members of this congressional committee continues. And above all else, let's hope as we proceed to implement H.R. 1156 that we don't repeat the mistakes we have made over the last 14 years.

For example, our current alcohol and drug abuse treatment programs continue to be grossly understaffed. This has resulted in marginal treatment services due to high rates of chemical dependency counselor burn out and turnover. This in turn, makes it difficulty to recruit and retain qualified CD counselors. Part of this problem rests with the fact that there has not been a uniform alcohol and drug abuse counselor training program adopted nationwide. We have witnessed training that covers a multitude of topics (some alcohol and drug oriented and some not) with an equally wide range of training models from workshops to college level courses. Basically we have failed to adopt a college level alcohol and drug training model that standardizes information, has career ladder capabilities, increases counselor competency levels, and teaches research skills. I simply cannot believe we would accept such a haphazard model of training for nurses, teachers, medical doctors, etc. If alcoholism and drug abuse is truly the major health problem facing Indian people today, how can we continue to prepare CD counselors so casually. I challenge you to name another minority group in this country that would accept this mediocre level of service. Chemical Dependency Counselor certification has been proposed as the solution to achieve quality care. How is this to be accomplished given the inconsistent alcohol and drug training and high alcohol and drug counselor turnover rates that permeate the entire Indian Chemical Dependency Treatment efforts? And lastly, it seems to me that the chemical dependency treatment field has in the last 14 years failed to enlist short or long term support from their respective tribal officials. I have not seen a tribe in the plains area that has designated alcohol and drug abuse as their number one priority and marshalled all available resources to bare on this problem. It is one thing to say alcohol and drug abuse is the number one health problem and quite another thing to bring all available resources to focus on this problem. Since these represent mistakes we have made in the past 14 years of dealing with Indian Alcohol and Drug Abuse, may I suggest that H.R. 1156 consider juvenile alcohol and drug abuse prevention as a permanent part of Indian health and education. The problem of Indian Alcoholism and Drug Abuse is of a magnitude that we no longer have the luxury to think it will be solved with-minimal short term efforts. We need to think in terms of permanent long term services if we are to succeed. To better understand what I mean, let's momentarily compare the field of alcohol and drug abuse with education. In most cases, the educational facility is fairly adequate, probably a low B grade while the vast majority of alcohol and drug facilities would receive a bonus if they were graded above a D. Schools have professional faculty and administration who have received uniform and consistent career ladder oriented training that includes research and must show evidence of successful completion of this training to qualify for employment. Alcohol and drug abuse counselors on the other hand enjoy none of these benefits. They have no standards to meet, no formal educational model to pursue nor are they required to meet specific job qualifications nor do they have a career ladder. Do I need to say more?

Should we not be aware of the fact that the field of Indian Alcohol and Drug Abuse is the most grossly underresearched health area in the United States today? Even though we have been treating this problem for fourteen years, we know relatively little about it. If our efforts are to reach the level of success necessary to guarantee Indian survival, then we must conduct at least minimal research. We can no longer continue to deal blindly or rely on the famous "trial and error" method of problem solving. When research is considered, would it not make a whole lot of sense to have it conducted in alcohol and drug treatment programs by Indian alcohol and drug abuse counselors? When this process begins, it seems to me that permanent-positive change will follow.

My final comment is directed specifically at H.R. 1156. I hope that when we focus on Indian Juvenile Alcohol and Drug Abuse we recognize the entire reservation community must become a huge support system if success is to be achieved. Every man, woman, and child must ultimately understand their role and responsibility in the continued resolution of this problem. I am suggesting that the training and service efforts proposed in H.R. 1156 not be limited to BIA, IHS, school, and alcohol and drug abuse officials.

If we want to taste success, then mothers, fathers, brothers, sister, aunts, uncles, grandparents, in-laws, friends, and any one else residing in Indian communities must be involved, educated, and motivated to help.

If this concept is present when H.R. 1156 is considered by your congressional colleagues then not only will 1156 be a stronger program but our last 14 years will not have been in vain. It is conceivable that Indian youth may through H.R. 1156 be the salvation for all Indian people.

Thank you for the opportunity to present my remarks. I will be happy to answer any questions.

DEPARTMENT OF ALCOHOL AND DRUG ABUSE STUDIES
ROOM 304 JULIAN HALL
DIVISION OF HEALTH SCIENCES
COLLEGE OF ARTS AND SCIENCES
UNIVERSITY OF SOUTH DAKOTA
VERMILLION, SOUTH DAKOTA 57069
PHONE 605-677-5386

The Alcohol and Drug Abuse Studies Department at the University of South Dakota is designed to impact one of the nation's major health problems, alcohol and drug abuse. The Department provides a comprehensive curriculum vital to any total health care service system and encourages an awareness of the interdisciplinary ramifications of alcohol and drug abuse. The specific objectives of the Department are:

1. To develop people capable of delivering professional services in the treatment of alcohol and drug abuse.
2. To develop a cadre of personnel with the ability to substantially reduce the present incidence of alcohol and drug abuse.
3. To enable graduates of the program to understand and apply the results of research and evaluation on alcohol and drug abuse.
4. To provide student majors with an interdisciplinary program directed to all facets of alcohol and drug abuse.
5. To provide students of other fields with a basic knowledge of alcohol and drug abuse and contemporary treatment methods.

PROGRAM PHILOSOPHY:

The Department of Alcohol and Drug Abuse Studies serves three primary purposes:

1. To prepare students for practice in the field of Alcohol and Drug Abuse.
2. To provide a sound foundation for an entry-level involvement in primary health care services.
3. To provide knowledge of alcohol and drug abuse to persons concerned with primary health care.

DEPARTMENT COMPONENTS:

Students participating in all phases of the Alcohol and Drug Abuse Studies Department have opportunities to gain: (1) theoretical expertise in the nature, causes, prevention, and treatment of alcohol and drug abuse; (2) applied expertise in the development of professional skills including communication, empathy, evaluation, and facilitation of primary care, coordination of services, management of programs, and referral functions, and (3) self-understanding of personal and professional potential in the alcohol and drug abuse service field.

DEPARTMENTAL GOALS FOR PROFESSIONAL COMPETENCY:

The Department is designed to provide the academic preparation of students for two levels of entry into the field of Alcohol and Drug Abuse.

Degree Program - a program of at least 128 semester hours, including 33-36 semester hours of courses in alcohol and drug abuse, leading to the degree Bachelor of Science in Arts and Sciences with a major in Alcohol and Drug Abuse.

Certificate Program - students not desiring the Baccalaureate Degree have the option of participating in the Professional Associate Certificate Program. The Professional Associate Program requires completion of 64 semester hours including 18 semester hours of alcohol and drug abuse studies courses. (Note this is not an Associate Degree).

With guidance from the Department staff, a student may choose the program which best suits his/her immediate abilities, life situation, and professional goals with the knowledge that higher levels of professional competency may be pursued in the future from the level he/she has chosen. College credits earned in the Certificate Program may be applied to the Degree Program.

ADMISSIONS CRITERIA:

Information concerning general requirements for admission to the University, tuition, fees, etc., should be obtained from the Office of Admissions, Slagle Hall, University of South Dakota, Vermillion, South Dakota 57069. Telephone: 605-677-5434.

In addition to meeting general University requirements, admission as an Alcohol and Drug Abuse Studies major also includes consideration of a student's academic potential, maturity, health, length of abstinence for chemically dependent individuals, motivation, and self-awareness.

OUTREACH AND ON-CAMPUS COMPONENTS:

The Department of Alcohol and Drug Abuse Studies (ADAS) is divided into two components, the outreach component and the on-campus component.

OUTREACH:

The outreach component is designed to provide educational opportunities for individuals who are unable to matriculate full-time to a college campus and consists of evening and module courses. Evening classes are taught throughout South Dakota by qualified adjunct faculty who reside in the community where a given course is taught. Each class meets weekly (usually at night) for three hours for fifteen weeks each semester. Schedules for these classes are developed by the adjunct faculty member responsible for each course.

Departmental courses are also delivered through a two-step instructional model referred to as "module" courses. The first step in this format consists of a week-long block of classroom instructional time totaling a minimum of 45 consecutive student teacher contact hours. Step two requires the completion of a predetermined number of take-home activities that emphasize and reinforce various content areas covered during the classroom instruction. After the required take-home activities have been satisfactorily completed, a final examination is administered.

The classroom activities of each module are designed to provide a balanced program of lectures and discussion groups covering all of the courses' subject matter. This gives participants both an overview of the scope of the course and a firm base from which to pursue the non-classroom activities. The assigned textbook, films and tapes, input from professionals in the field and opportunities for experiential learning, where applicable, are utilized during this part of the course.

The non-classroom activities are guided by the assigned text (or texts) and a syllabus. Upon completion they are returned to the Alcohol and Drug Abuse Studies Department for grading by the ADAS faculty.

After satisfactory completion of the classroom and non-classroom activities a final examination covering the entire course is sent to a qualified person at the student's home site who will administer the examination and return it to the ADAS Department faculty for grading.

A time limit within which the entire module must be completed is based on the number of non-classroom activities required in a particular course.

Off-campus students are eligible to participate in both evening and module courses during the same semester.

ON-CAMPUS:

The on-campus department is the same as any other departmental program. The population served by the on-campus department includes a number of recent chemically dependent persons matriculating full-time, current University students, and transfer students.

REQUIREMENTS FOR THE DEGREE, BACHELOR OF SCIENCE IN ARTS AND SCIENCES WITH A MAJOR IN ALCOHOL AND DRUG ABUSE STUDIES:

Minimum requirements for the Bachelor of Science Degree with a major in Alcohol and Drug Abuse is 128 semester hours.

GENERAL EDUCATION REQUIREMENTS:

Students desiring to complete either the certificate program or the Bachelor of Science degree must complete a number of general education requirements in addition to the prescribed course work in the alcohol and drug abuse studies major. Credits earned at accredited two or four year institutions are generally transferrable into these programs.

BASIC REQUIREMENTS:	SEMESTER HOURS
Freshman English	6
Social Science	12
Humanities	12
Mathematics	11
Natural Science	12
Electives	17

Minor (one minor of at least 18 hours) 18-36

Social Science - 12 credit hours (two or more disciplines; at least 3 credits of upper division course work).

Humanities - 12 credit hours (two or more disciplines).

Mathematics - 11 credit hours (including 8 credit hours sequential courses with MATH prefix above MATH 101, remaining hours may be elected from MATH above MATH 101, Computer Science, or Statistics).

Natural Science - 12 credit hours (2 or more departments, including 8 credit hours sequential laboratory science in one discipline prefix).

The following alcohol and drug abuse studies courses (ADAS) constitute the major and are required for the Bachelor of Science degree: Major course requirements - ADAS 116, 117, 120, 216, 217, 315. Major elective courses: ADAS 115, 316, 317, 320, 417, and 420. ADAS 115 and ADAS 320 are applicable to the major only with written departmental approval.

DEPARTMENT OF ALCOHOL AND DRUG ABUSE STUDIES SUGGESTED COURSE SEQUENCE FOR PROFESSIONAL ASSOCIATE CERTIFICATE

FIRST YEAR	1ST SEMESTER	2ND SEMESTER
ADAS 116 Introduction to Alcoholism	3	
ADAS 117 Introduction to Drug Abuse	3	
Freshman English	3	3
Social Science (rec: SOC 100 Intro to Sociology or rec: PSYC 101 General Psychology)		3
Humanities (rec: SPCM 101 Fundamentals of Speech)	3	
ADAS 120 Helping Skills		3
ADAS 217 Group Interaction		3
Natural Science (BIOL 101)	4	
(BIOL 103)		4
	16	16

SECOND YEAR	1ST SEMESTER	2ND SEMESTER
Humanities (rec: ENG 303 Organizational Writing)	3	
Social Science (rec: CJUS 201 Intro to Criminal Justice)	3	
(rec: PSYC 322 Psyc. of Human Development)	3	
(SOC 261 Human Sexuality)	3	
Math (rec: MATH 111 College Alegbra)	4	
Math 112		4
ADAS 315 Treatment (Pre: ADAS 116, 117)		3
ADAS 317 Treatment Field Practicum (pre: ADAS 316 & C.D.)		3
CJUS 250 Intro to Crime & Deliquency		3
ADAS 316 Special Problems		3
	16	16

rec: = recommended
C.D. = consent of department
pre: = prerequisite
C.I. = consent of instructor

RECOMMENDED SCHEDULE AND DRUG ABUSE STUDIES MAJORS

	Semester	
Freshman Year	1st	2nd
ADAS 116	3	
ADAS 117		3
BIOL 101	4	
BIOL 103		4
ENGL 101	3	
ENGL 163		3
MATH 111	4	
MATH 112		4
SPCM 101	3	
PSYC 101		3
	17	17

	Semester	
Sophomore Year	1st	2nd
ADAS 120	3	
ADAS 216		3
ADAS 217	3	
ADAS 316		3
ENGL 203		3
PHGY 210	4	
PSYC 165	3	
PSYC 251		3
SOC 100	3	
ANTH 100		3
Electives	1	2
	17	17

Junior Year		
ADAS 315	3	
ADAS 317		1-3
ENGL 300	3	
POLS 210 or 317		3
PSYC 322 or 364		3
CSCI 101		3
SPCM 310	3	
Electives	6	3
	15	15

Senior Year		
ADAS 417	3	
ADAS 418		3
ADAS 420	1-3	1-3
ANTH 261	3	
PHIL 323		3
CJUS 250		3
SOC 350		3
Electives	6	
	15	15

COURSES FOR A MAJOR IN ALCOHOL AND DRUG ABUSE STUDIES

**Major---33 Credit Hours

Major Requirements-To Equal 18 Credit Hours

Dept. and Prefix No.	**Title of Course**	**Semester Hrs. Cr.**
ADAS 116	Introduction to Alcoholism	3 hrs.
ADAS 117	Introduction to Drug Abuse	3 hrs.
ADAS 120	Alcohol and Drug Abuse Helping Skills	3 hrs.
ADAS 216	Working with Families of Alcohol and Drug Abusers	3 hrs.
ADAS 217	Alcohol and Drug Abuse Group Interaction	3 hrs.
ADAS 315	Treatment of Alcohol and Drug Abuse	3 hrs.

Major Electives-To Equal 15 Credit Hours

ADAS 316	Alcohol and Drug Abuse Special Problems	3 hrs.
*ADAS 317	Alcohol and Drug Abuse Treatment Field Practicum	1-3 hrs.
ADAS 417	Alcohol and Drug Abuse Helping Skills Lab.	3 hrs.
ADAS 418	Alcohol and Drug Abuse Group Interaction Lab.	3 hrs.
*ADAS 420	Independent Field Experience	1-6 hrs.
ADAS 115	Workshop in Alcohol and Drug Abuse	1-3 hrs.
ADAS 320	Independent Study in Alcohol and Drug Abuse	1-3 hrs.

**Students completing this major must have no less than a "C" in each required course and a cumulative G.P.A. of 2.0 in the elective courses.

*Credit hours for these courses will be determined utilizing the following ratio:

(a) 100 supervised on site hours will constitute 1 credit hour
(b) 130 supervised on site hours will constitute 2 credit hours
(c) 160 supervised on site hours will constitute 3 credit hours
(d) 200 supervised on site hours will constitute 4 credit hours
(e) 240 supervised on site hours will constitute 5 credit hours
(f) 280 supervised on site hours will constitute 6 credit hours

COURSE TITLE: ADAS 115 Workshop in Alcohol and Drug Abuse

1-3 Credit Hours - Lower Division

An overview of various theories of the causes, origins, and development of alcohol and drug abuse designed to provide a broad theoretical introduction to the field of alcohol and drug abuse introducing the student to the scope of this major health problem. When content changes, may be repeated 3 times.

COURSE TITLE: ADAS 116 Introduction to Alcoholism

3 Credit Hours - Lower Division

A survey of the use, abuse, and addictive nature of ethyl alcohol and the symptomatology and treatment of alcoholism, providing the student with a basic knowledge of its nature, scope, and complexity and the wide range of current approaches to its treatment and prevention.

COURSE TITLE: ADAS 117 Introduction to Drug Abuse

3 Credit Hours - Lower Division

A survey of mood-altering chemicals other than ethyl alcohol and the symptomatology and treatment of the abuse of them, providing facts and insights concerning the abuse of a wide variety of "legal" and "illegal" mood-altering chemical substances and approaches to treatment and prevention of dependency upon them.

COURSE TITLE: ADAS 120 Alcohol and Drug Abuse Helping Skills

3 Credit Hours - Lower Division

An introduction to skills useful in dealing with people who abuse alcohol and drugs by introducing the student to basic communication and helping skills appropriate to dealing with people suffering from alcohol and drug abuse, giving the student working knowledge and academic experience with those skills.

COURSE TITLE: ADAS 217 Alcohol and Drug Group Interaction

3 Credit Hours - Lower Division

An introduction to working with groups of people who abuse alcohol and drugs by introducing the student to the basic dynamics of small groups and facilitative skills appropriate to working with those groups in the management of alcohol and drug abuse, giving the student working knowledge of and academic experience with those skills.

COURSE TITLE: ADAS 216 Working with Families of Alcohol and Drug Abusers

3 Credit Hours - Lower Division

A survey of the needs of, and relevant help to the families of alcohol and drug abusers, focusing on the very special needs of members of the families of alcohol and drug abusers, providing the student with insight into those needs, the symptoms of alcohol and drug abuse afflicting those family members, and methods of understanding and helping themselves as well as the active alcohol and drug abusers.

Prerequisites: ADAS 116 and ADAS 117 and consent of instructor

COURSE TITLE: ADAS 315 Treatment of Alcohol and Drug Abuse

3 Credit Hours - Upper Division

This course will emphasize the concept that treatment of alcohol and drug abuse is a continuum of processes from intervention through rehabilitation. To acquaint the student with the integral parts of that continuum and the ways in which it addresses the needs of people suffering from alcohol and drug abuse.

Prerequisites: ADAS 116 and ASAS 117

COURSE TITLE: ADAS 316 Alcohol and Drug Abuse Special Problems

3 Credit Hours - Upper Division

An intensive, in-depth examination of alcohol and drug abuse issues. Issues examined will vary from semester to semester. May be repeated with consent of the instructor.

COURSE TITLE: ADAS 317 Alcohol and Drug Abuse Treatment Field Practicum

1-3 Credit Hours - Upper Division

Supervised work experience in a variety of accredited alcohol and drug abuse treatment programs, offering the student supervised exposure to the workings of a variety of accredited alcohol and drug abuse programs across the full spectrum of treatment. This will provide the student with insight into the "real world" of the field, an opportunity to experience different aspects of the field, and occasion to test his vocation in the various aspects of the treatment continuum.

Prerequisites: ADAS 315 and consent of department

COURSE TITLE: ADAS 320 Independent Study in Alcohol and Drug Abuse

1-3 Credit Hours - Upper Division

Supervised individual reading and/or research on selected topics and in selected areas of Alcohol and Drug Abuse Studies. Open to Juniors, Seniors, and graduate students with the consent of the departmental staff. Limited to 6 credit hours.

COURSE TITLE: ADAS 417 Alcohol and Drug Abuse Helping Skills Laboratory

3 Credit Hours - Upper Division

A laboratory in refining helping skills used in treating alcohol and drug abuse, designed to provide the student with laboratory experience in refining and applying appropriate helping skills to the various aspects of the alcohol and drug abuse treatment continuum and in the development of educational and preventive programs, helping the student to integrate academic theory and skill-building in a controlled environment conducive to professional growth through critical evaluation.

Prerequisites: ADAS 116, 117, 120 and consent of instructor

COURSE TITLE: ADAS 418 Alcohol and Drug Abuse Group Interaction Laboratory

3 Credit Hours - Upper Division

A laboratory in refining participatory and facilitative skills in the prevention and treatment of alcohol and drug abuse, emphasizing: (1) participation with students from other health disciplines in learning to develop interdisciplinary primary health care teams and (2) the application of facilitative skills in group interaction in simulated treatment and preventive approaches to alcohol and drug abuse.

Prerequisites: ADAS 116, 117, 217 and consent of instructor

COURSE TITLE: ADAS 420 Independent Field Experience

1-6 Credit Hours - Upper Division

An intensive experience under supervision in an accredited alcohol and drug abuse facility to provide the student with an opportunity to gain working knowledge and experience in the field of alcohol and drug abuse services through supervised participation in a single alcohol and drug abuse facility throughout an entire semester or summer session.

Prerequisite: ADAS 317 and consent of the department

Flandreau Santee Sioux Tribe
Tribal Health Department

P.O. Box 283 *Flandreau, S.D. 57028*
Phone: (605) 997-3922

JUN 11 [illegible]

Honorable Mr. Tom Daschle
Member of Congress
439 Cannon Office Building
Washington, D.C. 20515

Sir:

I feel privileged to have an opportunity to submit my testimony in support of HR.4567, The Indian Health Care Improvement Act. Specifically the amendments dealing with substance abuse with Indian adolescents.

My perspective is that of an individual who has worked with Native American veterans and their families in an alcoholism treatment program with the Veterans Administration for over eight years and as a program director with an adolescent alcohol and drug treatment program on the Pine Ridge Reservation for over two years. I am painfully aware of the alcoholism rate among Native Americans and know that it far exceeds the national averages.

The population of Native Americans in South Dakota is 6% as of a 1970 cesus. The alcoholism rate among this minority group is 82.1%. The Native American veterans recieving treatment for substance abuse is 45% at any given time in the treatment cycle of a VA inpatient unit. There are nine Indian reservations covering about 10% of the land in the state. Demographic characteristics of the Indian population indicates some of the worst and most devastating economic and social effects in the study. Families living in poverty on Indian reservations range from 31.8% to 49.3% as compared to a state average of 14.8%. Unemployment ranges from 40% to 70% for reservation Indians compared to 3.4% for the South Dakota white population.

In 1970 life expectancy was 48 years for Indians vs 68 years for the United States as a whole and 72 years for the South Dakota white population. Median education level for Indians 25 years and over is 9.6 compared to a state average of 12 plus years.

The South Dakota reservation alcohol related deaths is 61.2% per 100,000 compared to 8.4% nationally and 10.4% in South Dakota as a whole. (Statistics from needs assessment study conducted by Hot Springs VA Medical Center 1979)

The point is, these Indian veterans are heads of households, have children and grandchildren. These children are products of their environment and inherit attitudes of their parents. The cycle of alcoholism and drug abuse perpetuates more of the same social, economic, family, judicial, and physical problems. I maintain, the Indian people are committing cultural suicide. The potential in human resources wasted is of epidemic proportions.

To successfully interupt this cycle, combined efforts must be directed at Indian youth who are the people of the future. Due to limited services available to Indian youth to successfully combat alcohol and drug abuse a majority of these youth never get the services they need.

My personal experiences while employed at Project Phoenix in Kyle, South Dakota is one of almost unbelievable situations affecting teenagers referred for services and treatment. From substance abuse to physical abuse, neglect, sexual abuse and incest -- all of this can be attributed to alcohol and drug misuse and abuse by all members of the family.

This proposed bill reauthorization and amendments will be the vehicle the Indian people need to effectively address the issue of substance abuse with youth.

Thank you for allowing me to have an input in this very important legislation for Indian youth.

Should you need additional information feel free to call or write me.

Sincerely;

Philip Under Baggage
P.O.Box 283
Tribal Counseling Services
Flandreau, South Dakota 57028
(605) 997-3844

STATEMENT OF JERRY JAEGER, AREA DIRECTOR, ABERDEEN AREA OFFICE, BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE HEARING OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS, HOUSE OF REPRESENTATIVES, ON H. R. 1156, THE "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT", IN RAPID CITY, SOUTH DAKOTA, MAY 28, 1985.

Good Morning. My name is Dr. Jerry Jaeger. I am the Aberdeen Area Director for the Bureau of Indian Affairs. The Department of the Interior has not taken a position on H. R. 1156.

I am pleased to be here today to talk about the very serious problems of Indian juvenile alcohol and drug abuse.

The Bureau of Indian Affairs recognizes the need to begin working with our youth at an early age to help them understand the problems and effects of alcohol and drug use. Our schools are required to include an alcohol and drug prevention program as part of their curriculum and our Agency Superintendents for Education are held responsible for assuring that these programs get implemented by having this requirement as part of their performance appraisals. Because the type and extent of the program developed is a local school decision, the programs vary significantly. Frequently programs are developed in coordination with the local Indian Health Service representative and the tribe and may be as simple as including a unit on the subject as part of the health curriculum, or as extensive as having speakers and special materials in each classroom throughout the year. In addition, the schools may get involved in referrals to the IHS or the tribal court if a student attends school while intoxicated or under the influence of drugs.

The BIA's Law Enforcement and Social Services staffs may also become involved in referring to the IHS a juvenile who apparently has an alcohol or drug abuse problem. Generally a juvenile is incarcerated until "dryed out" and then is released to the parents custody. Only when a juvenile has had repeated arrests will the court get involved. At this time there are no juvenile detox centers available in the Aberdeen Area for referral. However, we do have a foster care program which includes juveniles that have alcohol and drug related problems. It is very difficult to place these teens into appropriate foster homes and therefore, they are generally placed with a member of their extended family.

There are no special facilities in the Aberdeen Area to specifically house juveniles arrested for alcohol and drug related crimes. There are however, special facilities that are used specifically for juveniles. For example, the Crow Creek Tribe operate a facility at Ft. Thompson, South Dakota, for juveniles who are run-a-ways or are considered to have social problems. Also, the Bureau of Indian Affairs is in the process of renovating several jails in the Aberdeen Area to separate adults and juveniles. These projects will be completed in the next year.

Several tribes in this Area participated in a recent study done by the Colorado University entitled "Trends in Drug Use of Indian Adolescents Living on Reservations: 1975-1983." The study concluded that "From 1975 through 1981, there were six years of increasing drug involvment among Indian youths. Since 1981 there may be, at last, a trend toward lower rates of exposure to drugs. The drop in use is occuring both in the percent of young people who are trying a drug and in the lack of current use of individual drugs. . . . Despite the recent reduction, drug use rates for Indian youth are still exceptionally high and continue to be grounds for serious concern. About 50% of Indian youths are now at some risk due to this drug and alcohol use." I do not have a copy of the study readily available, however our Washington Office does have a copy that could be furnished to the Committee.

This concludes my prepared statement and I will be happy to answer any questions the Committee may have.

Mr. Chairman, members of the House Committee on Interior and Insular Affairs. My name is Dr. Terrence Sloan, Area Director of the Aberdeen Area Indian Health Service, and I have been asked to provide you with information regarding Indian Health Services for Indian juveniles relative to alcohol and drug abuse. I am accompanied by Dr. Lois Steele, Director of the INMED program.

The primary health delivery system for alcohol and drug services in the Aberdeen Area Indian Health Service is through a system of 22 tribal contracts most under Public Law 93-638 and a few under the Buy-Indian Act. Eighteen of these programs were formerly funded by National Institute of Alcohol and Alcohol Abuse grants which were transferred to Indian Health Service beginning in Fiscal Year - 1978. In addition we have four alcoholism programs funded through health equity monies. These 22 contracts include a variety of program components from education, prevention, evaluation, and treatment and rehabilitation aftercare. With the exception of Project Phoenix, a juvenile treatment center at Kyle, South Dakota, these programs stressed acute intervention and were initially targeted to serve clientele who had established alcohol abuse patterns. In 1982 our emphasis shifted to prevention, in order to improve the overall effectiveness of the program.

Referrals for counseling or treatment are currently made to the tribal contract providers based upon their notification to us as to services provided and potential outcome. If the tribal contract providers cannot provide the service, this attempt to utilize other sources such as Project Phoenix, the Adolescent units of the State Hospitals, or private facilities.

These contract programs report serving 169 juveniles on an outpatient basis during the last 12 months. Project Phoenix reports a total of 510 inpatients since 1982.

Juveniles who need medical services are seen in clinic or admitted to our facilities the same as are other Indian Health Service patients. We recognize alcoholism as an illness within our Hospital and Clinics medical delivery systems and in Fiscal Year-1984 our staff served 24 juveniles as inpatients, 77 juveniles as outpatients, and 6 under contract health referral status. The Area Alcoholism Coordinator, the staff of the Drug Dependency Unit located at the Winnebago PHS Indian Hospital, and the staff of the Detoxification Unit located at the Belcourt PHS Indian Hospital, are identified Indian Health Service Staff whose primary duties are to work with alcohol and drug abuse.

IHS is responsible for diagnosing and treating health problems caused or related to excessive use of alcohol and drugs. Indian Health Service Community Health programs share with tribal contract programs the responsibility for prevention activities.

Indian Health Service contracts with Indian governing bodies which in turn provide alcohol and drug abuse services. We are then responsible for monitoring these contracts to assure quality services are delivered as contracted.

In the area of prevention there are six community based programs which do solely preventive work. Each of these preventive programs work with Fetal Alcohol Syndrome; Babes - Basic education series covering Headstart to grade 3; Project Charlie (Grades 4-7), and all utilize audiovisual materials in schools. They provide alternative activities for youth such as poster contest, youth runs, feasts, campouts, sweats, dances, swimming, competitive sports and other culturally related activities. There are alcohol awareness weeks and both Indian Health Service and tribally contracted programs promote these in Health Fair activities.

We appreciate the interest of this committee in this topic of mutual concern and thank you for the opportunity to explain Indian Health Service activities on behalf of Indian youth with alcohol and drug abuse problems.

SANTEE-SIOUX ALCOHOL PREVENTION and DRUG AWARENESS PROGRAM

Niobrara, Ne. 68760
Phone 402-857-3509

The Santee Alcoholism Program, located in Santee, Nebraska wishes to lend their support to Congressmen Doug Bereuter (R-Neb.), Tom Daschle (So. Dak.), Morris Udall (Ariz.), Pat Williams (Mont.), and Doug Young (Alaska) for their introduction of H.R. 1156 to the U.S. House of Representatives. This bill focuses on prevention activities as the way to deal with alcohol and drug abuse among Indian Youth.

The administrators for the tribe and the alcohol staff are all well aware of the existing problems resulting in chemical abuse among our young Native Americans. The Health Programs deal with accidents, sicknesses, injuries and oftentimes death, due to this terrible malady existing on our reservation. One needs only to consult the health records to become aware of the devastating impact this disease is causing our people. We suffer many times over the statistics quoted on a national level, ratiowise.

Alcohol, being the major cause of this community sickness, can only be combated by the Federal Government assisting the Indian Alcohol Programs, which are struggling for existence with the budget allocations being as they are. This program recognizes the need for prevention activities as the major thrust in making an impact on the present problems. Our youth are experimenting at an earlier age and in greater numbers, mind altering chemicals which include inhalants, (glue, gasoline, paint etc.) not to mention alcohol and drugs, oftentimes, the case being a substance entirely unknown to the people using it. This is because of inactivity for our youth. They have nothing to do! There are no on-going activities centered on alcohol-education because we simply do not have the money.

A community-based treatment center would benefit juveniles who have been arrested for alcohol or drug related offenses, in lieu of being jailed. Specially-trained people at all stages of dealing with juveniles are needed, as is the equipment to foster any activity which might center on this goal.

When the Great Spirit put his Red-People here as keepers of Mother-Earth, he instilled in them the knowledge and wisdom of walking ij this life in harmony with all other creation. The introduction of alcohol and other evils have disrupted this life-style. We need to learn how to walk again. Our prayers are with you in behalf of your concern over this problem. Respectfully.

Chairman, Santee-Sioux Tribe

Robert B. Mackey
Director, Alcohol Program

Roger Trudell
Business Manager, Santee-Sioux Tribe

Richard Lasley
Counselor, Alcohol Program

Red Cloud Indian School
Holy Rosary Mission
Pine Ridge, South Dakota 57770

May 28, 1985

Rep. Morris K. Udall, Chairman
Committee on Interior and Insular Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Rep. Udall:

I am writing this in support of the Indian Juvenile Alcohol and Drug Abuse Prevention Act. It is to be included in the record of the hearing regarding this Act.

I have been working for Red Cloud Indian School, Inc. since September of 1984 as a specialist in chemical dependency. I have done counseling, education, and networking with schools, the Tribal Court system, the social service system, and various human service agencies on the Pine Ridge Reservation over the past year.

It has become apparent that chemical abuse/dependency and related family problems, especially child abuse (sexual, physical, and emotional) are among the greatest problems on the Reservation. They exist in epidemic proportions and have greatly damaged the family structure of the Lakota people.

There is a growing awareness of chemical dependency and child abuse on the Pine Ridge Reservation. This happens through the schools, the radio station, and human service agencies. Money for this is not readily available and is obtained on a "hit and miss" basis. Many people working in the fields of education and human services have no training in the areas of chemical dependency and child abuse. This is a serious gap in a locality where the rates of both are high above national averages.

Education and prevention about chemical dependency and related problems, especially child abuse, is sorely needed for young generations of Indian people. These problems will continue to be passed down to future generations unless serious action is taken.

Sincerely,

S. Barbara h Corson
Sister Barbara Corson, ND, MSW
Specialist in Chemical Dependency

ST. FRANCIS MISSION
Chemical Dependency Unit
P.O. box 146
St. Francis, So. Dak. 57572

Fr. Robert Fitzgerald, S.J.
Director

Delores Mesteth
Family Program Developer

Dear Rep. Morris Udall,

I have been a director of a small outreach CD unit here for five years and am a certified alcoholism counselor in the state of South Dakota. I thank you and your team supporting HR 1156 "Indian Juvenile Alcohol and Drug Abuse Prevention act."We need it, the problem is real.

For example, a fellow priest who taught for years in St. Francis Indian School one night could not get to sleep. He started counting the boys he had taught who had died of alcoholism. He got to 80 before he fell asleep. Dr. Fred Beauvais did a survey of drug use in the school here three years ago. As you know, he has surveyed schools across the country. We were above the national average in alcohol and drug use in the high school with 13% of high school into heavy polydrug use. There is no youth treatment center here exceppt Project Phoemix on the next reservation over and they have enough to do with their own youth. We need a prevention counselor and the training the bill indicates for those adult professionals coming into contact with addicted youth. Many now have their eyes clsed and kids get passed on. This Monday I was called from Custer where a dropout from our school had run away to another counselor. The counselor was trying to get help for the girl but the treatment pricetags were too high: 5,000 and 8,000 dollars in adult treatment centers. We are trying to get her into a state program for adolescents but there will be a waiting list and her problem is so bad that during a waiting period she will act out and run. We need youth treatment centers and skilled people with a intervention and referral policy and skills.

A friend said our schools are like auto factories that at graduation send out shiny new cars--only to see them wrecked within five years. I wish you could share some of the helplessness adults caring for youth feel when there is no place where addicted youth can get treatment. When I taught in Minneapolis,I saw an alert Adminstration of a school who could spot addicted youth and get them to treatment at St. Marys Hospital. The students on their return were an asset to the school and had their own noon hour support group. This could happen here with greater awareness among adults concerned with Youth and treatment centers for youth.

I like the bill. I have one reservation. I would hope that some clause could be added that would require the family of the student to be part of his/her treatment. It would be cruel to ask a student to get well, begin recovery, and them return to a sick family.

I am encouraged that at our school, there is a teacher and staff prevention team but they are facing much resistence and some structural leverage from on high like this bill would encourage their grassroots efforts for youth.

I thank you for your support of the bill. I ask that this be included in written testimony for the bill.

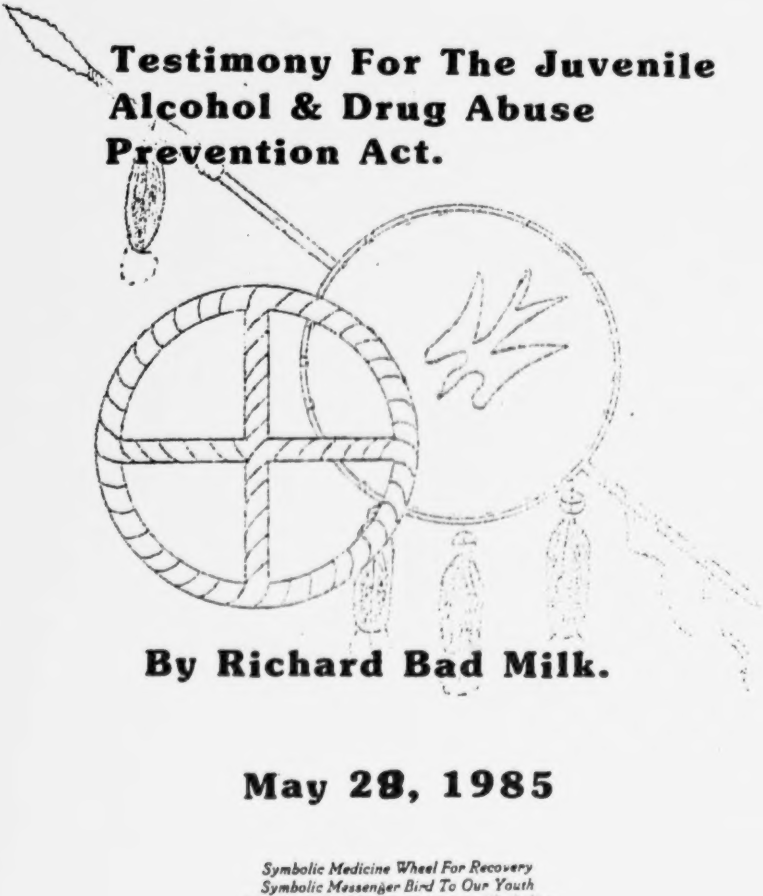
Sincerely
Fr Robert Fitzgerald
Fr. Robert Fitzgerald

May 15, 1985

TELEPHONE: (605)747-2222 2362

PROJECT PHOENIX
OGLALA SIOUX TRIBE

Testimony For The Juvenile Alcohol & Drug Abuse Prevention Act.



By Richard Bad Milk.

May 28, 1985

Symbolic Medicine Wheel For Recovery
Symbolic Messenger Bird To Our Youth
Shield And Staff To Battle Against Alcoholism

PROJECT PHOENIX
OGLALA SIOUX TRIBE

P.O. BOX 275
KYLE, SOUTH DAKOTA 57752
OFFICE PHONE: (605) 455-2382

HISTORY

Project Phoenix is a pilot program, which was established in an effort to combat alcohol and drug abuse on the Pine Ridge Reservation.

BACKGROUND

Project Phoenix is a non-profit, tax-exempt program established and chartered in 1979 by the Oglala Sioux Tribe to provide Native American youth with access to in-residence alcohol/drug/inhalent treatment. Project Phoenix received initial start-up funding from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1979, and the Oglala Sioux Tribe contracted continued support for the program from the Indian Health Service in October, 1982. The Board of Trustees for Project Phoenix consists of members of the Health Committee of the Oglala Sioux Tribe, who are elected district representatives elected at-large for two-year terms, and who also comprise membership from the nine political district subdivisions existing on the Pine Ridge Indian Reservation. Project Phoenix is located in the village of Kyle, South Dakota, which is in the Medicine Root District of the Pine Ridge Reservation. It is the only existing alcohol/drug residential treatment program for Native American youth in the midwest region, and serves youth ages twelve through seventeen who are referred through court order, self-referral, or referral by parents. Youth receiving residential care maintain educational pursuits at the Little Wound School, also located in the village of Kyle. The Little Wound School is a P.L. 93-638 Contract School system that provides educational services for grades K-12 students.

GOALS

To develop highly motivated youth who exhibit productive and responsible lifestyle behavior. The goal as stated, is an ultimate, long-range end result that when accomplished will reduce satisfactorily alcohol and drug problems stated as such, the goal is not measurable, nor time-limited, but one that Project Phoenix is directed towards via four program component areas; Prevention; Intervention; Treatment; and Follow-up. Objectives for component areas are provided: Operational definitions to make the objectives measurable, specific, time-limited and attainable are also stated to provide productivity indicators and standards which the objectives will be compared against in evaluating program accomplishment.

Symbolic Medicine Wheel For Recovery
Symbolic Messenger Bird To Our Youth
Shield And Staff To Battle Against Alcoholism

PREVENTION COMPONENT

OBJECTIVE #1: TO REACH THE YOUTH

Operation Definition - Project Phoenix will provide prevention activities to twenty-five percent of the students who attend Little Wound School and Oglala Community School by May 31, 1986.

OBJECTIVE #2: TO GAIN POSITIVE RESPONSE FROM YOUTH WHO PARTICIPATE IN PREVENTION ACTIVITIES

Operational Definition - At the end of each prevention activity, fifteen percent of the youth who participated will respond in the favorable categories of the evaluation sheet.

INTERVENTION COMPONENT

OBJECTIVE #1: TO DECREASE ALCOHOL/DRUG/INHALENT USE

Operational Definition - Assessment instrument administered to intervention referred clients will indicate a reduced use of Alcohol/Drug/Inhalent use for fifteen percent of this clientele at the time of program exit or at the end of the 1986 school year.

OBJECTIVE #2: TO INCREASE THE USE OF POSITIVE ALTERNATIVES TO ALCOHOL/DRUG/ INHALENT USE

Operational Definition - Ten percent of the intervention referred clients will have experienced self-help activities on at least three occasions as an alternative to alcohol/drug/inhalent use, as indicated by assessment conducted at the time of program exit or at the end of the 1986 school year.

TREATMENT AND FOLLOW-UP COMPONENT

OBJECTIVE #1: TO PROMOTE CLIENT ABSTINENCE FROM THE USE OF ALCOHOL/DRUG/INHALENT USE

Operational Definition - Twenty-five percent of the clients who complete treatment will have abstained from alcohol/drug/inhalent use for two months, as measured by the follow-up questionaire.

OBJECTIVE #2: TO INCREASE LEVEL OF SELF-WORTH

Operational Definition - Three quarters of the clients who complete treatment will rate themselves above level as measured by the self-esteem instrument as part of follow-up activity.

OBJECTIVE #3: TO REDUCE THE NUMBER OF REPEAT REFERRALS

Operational Definition - Seventy-five percent of the clients who complete treatment will not be referred a second time, by courts, schools, or families within the one year Project Phoenix is in operation.

TREATMENT AND FOLLOW-UP COMPONENT CONTINUED

OBJECTIVE #4: TO INCREASE THE EDUCATIONAL LEVEL OF UNDERSTANDING ABOUT ALCOHOL/DRUGS/INHALENT ABUSE AND GENERAL INFORMATION

Operational Definition - Three quarters of the clients who complete treatment will score above seventy percent on the written assessment to measure cognitive acquisition.

PROGRAM TIMETABLE

Activities to be conducted by Project Phoenix staff for clients are assigned to accomplish the objectives and ultimately the program goal. The activities are listed on the timetable. (See attached timetable) Activities may be added and some substitutions may be made to maintain program flexibility and allow for staff expertise and strength areas to enhance programming.

Administrative activities are not included on the timetable. These include, but are not limited to: Conducting P.L. 93-638 orientation; Developing Indian Health Service reporting system according to regulations; Staff training; Attending District Meetings for purposes of information exchange and public relations; Maintaining program and personal evaluations; Conducting some activities with counselors as listed on the chart. (See attached chart)

EVALUATION PLAN

NARRATIVE OF GENERAL EVALUATION APPROACH

General evaluation will consist of on-going, continuous evaluation through data gathering and analysis conducted by the Project Director. Recommendations to staff and improvements will be made based on data from: general observations; feedback from clients; information from daily logs; input from staff via weekly staffings; and information from a Management Chart. (See attched chart)

PROJECT PHOENIX PROGRAM

PROGRAM IDENTIFICATION:

In accordance with the provision of P.L. 93-638, the Oglala Sioux Tribe shall administer the PROJECT PHOENIX program.

TARGET POPULATION:

The target population fro this contract is the Oglala Sioux Indian People who live on the Pine Ridge Reservation. Approximately 1300, between the ages of 12-17, Oglala Sioux Will be served by Project Phoenix.

PROGRAM DESCRIPTION:

Project Phoenix as proposed, is a comprehensive program designed to focus on services to individuals who abuse alcohol/drugs, inhalents and experience related problems. Within Project Phoenix programming, are four basic components: Prevention; Intervention; Treatment; and Follow-up. Through these components, services are delivered to male and female adolescents ages 12-17. The major component, treatment, provides services on a twenty-four hour basis including room and board for clients as they progress through residential treatment.

PROGRAM CONCEPTS:

Project Phoenix utilizes a wholistic approach in its operation. That is, credence is given to cultural, spiritual, pyschological and social needs of clients. Project Phoenix operates in cooperation with schools, federal and state social services, and the courts. These entities and families make prospective referrals to Project Phoenix.

THE PROJECT PHOENIX PROGRAM IS DIVIDED INTO FOUR MAJOR COMPONENTS:

1. Prevention
2. Intervention
3. Treatment
4. After-care/Follow-up

PREVENTION:

The prevention program is primarily community based. The prevention program is designed to help youth and their families make responsible decisions about substance use. Project staff have provided hours of education about addiction and treatment to Pine Ridge Reservation people. Community education activities have included:

1. Speaking at community gatherings,
2. Sponsoring essay contests on the family, addiction, and other related topics through the Oglala Lakota College located on the Pine Ridge Reservation,
3. Providing awareness through programs on KILI, the local Indian-operated radio station,

PREVENTION: CONTINUED

4. Coordinating with local churches, Little Wound School in Kyle, and other organizations to increase awareness.
5. Promoting community activities and projects as an alternative to use of chemicals.

INTERVENTION:

The intervention program is available to help youth who are abusing substances, who are potential abusers, or who come from families with family members who are addicted. The core of the intervention program is the ALA-TEEN group sponsored by Project Phoenix. The group is modeled after Alcoholics Anonymous and provides group support for teenagers. Project Phoenix also provides individual intervention counseling and evaluation for youth and families. Staff provides community education to help families help members who are abusing chemicals.

TREATMENT:

The treatment program of Project Phoenix is residential. Youth are housed at Project Phoenix. They attend school at Little Wound School in Kyle, and educational facility that also has an extensive alcohol/drug prevention program. Residents of Project Phoenix spend their entire day in school or in treatment activities. During the summer, the entire day is spent in treatment activities.

Project Phoenix's treatment program is based on a unique blending of Indian culture, Alcoholics Anonymous philosophy and methods, and current addiction treatment methods. Young clients are taught, through experiences, and by learning from the modeling of the staff, the four basic Lakota values:

* Wisdom
* Generosity
* Respect, and
* Courage.

They are taught how to integrate these values into daily living.

They also learn and practice the twelve A.A. steps and attend A.A. or ALA-TEEN meetings on a regular basis. Clients are encouraged to develop their spiritual selves. Local churches and Indian spiritual leaders provide voluntary pastoral counseling and services.

The treatment program emphasizes learning new habits and relearning positive lifestyles. Residents learn through:

1. Individual, group, and family counseling,
2. Peer groups and positive peer pressure,

STAGE III: CONTINUED

ive phase to real life, without chemical dependency. Also apply learning to help others upon exit from center, and to have firm understanding of alternatives to use to replace chemcial dependency.

Purpose: Prepare client to live chemically free within their environment upon exit from center.

METHOD:

A basic group therapy model is used for group sessions. The goal in this model is for the person to discover themselves and others as feeling person and to identify the defenses that prevent this discovery.

Two counselors facilitate each session. They teach members of the group how to level feelings with each other and how to confront each other's defenses and malbehaviors. Members are taught to use these techniques with new members as they come into group, making the program self-perpetuating, by working for itself.

The counselors plan group sessions to address the needs of the clients. Emphasis is on spirituality, feelings, behavior and values. Counseling in the groups is basically non-directive allowing the clients to relieve emotional tensions, discover feelings, gain self understanding and to dfine goals. Staffing is done after each session.

TECHNIQUES USED ARE:

Lectures in areas such as understanding chemical dependency within the family context, grievance process, fetal alcohol syndrome, assertiveness training and others.

Speakers for teaching the clients Lakota values and religion. Also philosophy and meaning behind A.A. and others as the need arises.

Movies, video tapes and other media is used for appropriate material. These are especially useful educationally. The center has at its disposal documentaries made locally about alcoholism on this reservation.

Role playing is used for expressing feelings, dealing with behavior, problem solving, appropriate touching and others.

Arts and crafts are used which allow the client to develop self-competency.

The entire staff is encouraged to be creative and to keep up with new techniques in the area of alcoholic counseling for adolescents.

AFTERCARE/FOLLOW-UP:

One month after exit from Project Phoenix, contact is made to assess the family

3. Classes,
4. Work therapy,
5. Participating in leisure tiem activities,
6. Participating in spiritual activities of the church of their choice,
7. Attending ALA-TEEN and Alcoholics Anonymous meetings,
8. Helping with "family" tasks - cleaning, cooking, etc. in the residential setting,
9. Individual assessments,
10. Positive reinforcement and modeling by staff. (The entire staff is Native American.)
11. A discipline system that is based on learning, not punishment,
12. Integration of Indian cultural practices and mores into everyday life styles,
13. Counseling services and education for families of clients,
14. Working on community development projects.

An eclectic counseling model has evolved to meet unique needs of the diverse clients that come to Project Phoenix. Reality Therapy and Rational Emotive Therapy are the primery counseling modes. Both emphasize responsibility for self, logical decision-making, and the ability to accept the consequences of decisions made. The entire environment is operated as a therapeutic community. All staff, including clerical staff and the cook are trained to be a part of the treatment plan. Self-awareness activities, designed to increase self-knowledge and promote self-esteem are a part of daily activities. Counselors also have an A.A. back ground to draw upon individual and group counseling work in conction with one another. The individual counselors explain the process of group therapy to the client upon his/her admittance to the center. In these processess three stages of treatment are identified:

STAGE I:

Cognitive : Recognition of chemical dependency and development of intellectual abilities.

Purpose: Identify individual chemical dependency, learn the A.A. philosophy, learn the spiritual philosophy, identify values and behavior accompanying them, recognize and deal with feelings and develop self-awareness.

STAGE II:

Affective: Identifying and accepting changes needed to deal with chemical dependency.

Purpose: Change attitudes and behavior as they relate to chemical dependency. Develop spirituality, recognize feelings and values.

STAGE III:

Active: Learn to apply knowledge and attitudes learned in the cognitive and affect-support system of the clients. Within three (3) months, the gradual phase out of the client is completed. Up to this time clinic visits are arranged. One year after exit a questionaire is filled out by the client which determines the client's stability in combating chemical dependency.

FACILITY

Project Phoenix is currently housed in temporary facilities located in the village of Kyle, South Dakota. The facilities consist of two (2) 14' X 60' mobile home used for administrative office and kitchen/dining area. A combined unit complex is used for the dormitory, one side for girls, the other side for boys, and a dayroom where treatment activities are conducted. The facilities are available until such time that current plans for receiving permanent facilities are solictified.

EQUIPMENT:

Equipment in the facility consists only of that which is essential for maintaining present functions.

Office equipment is limited to carrying-out the essentials of daily activities.

Kitchen and dining room facilities consist of eight (8) assorted chairs and three (3) tables, a regular kitchen stove, refrigerator and cupboards.

Our transportation is almost nil. We have one van which is often in-operable. The monthly allocation for transportation goes into repairs for the van.

RESOURCES:

We rely heavily upon the local community for support in our program.

- * Spiritually - Pastors are very cooperative, giving talks and advice to youth.
- * Local churches are available, the children attend the church of their choice.
- * Little Wound School - The staff are supportive in providing home-work assignments and other educational needs.
- * The local A.A. and ALA-TEEN hold groups and provide speakers on a regular basis.
- * Okola Kiciye O Tipi (Pine Ridge) provides support groups for abused and neglect victims.
- * Project Recovery (Pine Ridge) assists in needed support methods.

Other institutions and agencies are utilized for training, information and support purposes. They are:

1. Hope Lodge, Sioux San Hospital, Rapid City, SD
2. West River Mental Health, Rapid City, SD
3. University of South Dakota, Vermillion, SD

4. State Social Services
5. The Oglala Sioux Tribal Courts

STATEMENT OF PROBLEMS

The National Indian Health Board has identified alcoholism as the major health problem among Native Americans.

The effects of alcohol/drug abuse on the Lakota youth living on the Pine Ridge Reservation has had devastating effects, and perpetuate existing socio-economic conditions for the Oglala Sioux, inclusive of:

1. The Pine Ridge Reservation is located in Shannon County, which is listed as being the most economically-deprived county in the nation.
2. The unemployment rate on the Reservation is estimated to average nine times the nation rate. Of 7,801 individuals who could be employed, only 39.1% are in the labor force (from Bureau of Indian Affairs Statistical Report, 1980) and only three thousand people have stable year-around jobs. (From a Lakota College survey, October, 1981.) The majority of the chronically unemployed are addicted.
3. A total of 97% of the families on the Pine Ridge Reservation have alcohol-related difficulties.
4. A total of 72% of all arrests on the Pine Ridge Reservation are directly attributable to alcohol/drug abuse.
5. Hospital reports indicate that 40% of all deaths on the Pine Ridge Reservation are alcohol-related.
6. Alcohol use contributes to 93% of all reported accidents on the Pine Ridge Reservation. 86% of accidents serious or fatal injury.
7. Alcohol/drug abuse contributes to 80% of all suicides on the Pine Ridge Reservation, and the suicide rate is estimated at five times the national average.
8. The student drop-out rate from Reservation schools is estimated at seventy-eight percent. A study conducted at one Reservation school, Little Wound, indicated that eighty-four percent of the drop-outs reported difficulties with addiction or the addiction of a family member as a major reason.
9. Fetal alcohol syndrome cases are increasing at an alarming rate on the Pine Ridge Reservation.
10. The majority of domestic violence which includes; spouse abuse, child abuse, and neglect are attributable to alcoholism and drug use.

Several resources have been initiated by institutions on the Pine Ridge Reservation to assist in combating the effects, as well as the prevention of alcoholism and other chemical abuse, however, most of the institutional resources have concentrated on providing resources for the adult population (Project Recovery, Halfway House, Pine Ridge Mental Health). Project Phoenix was developed to provide local resources for adolescents from this and other immediate areas to assist them with prevention, intervention, and treatment services with respect to chemical dependency, so the environmental and social conditions available to youth today need not be a pertual vision.

STATEMENT OF NEEDS

INTRODUCTION - existing facilities available to the project by virtue of their size limit the overall impact of Project Phoenix services because only (18) clients can be served at one time. There is a great need to impact the delivery of services to a minimum of (40) clientele on a daily basis to even begin to meet the needs of youth. Therefore, special needs indicate the acquisition of facilities that are at least double existing resources. At this time Project Phoenix is in a situation of having to not allow services to many youth that are in need due to inadequate, unsafe facilities.

At present, we have 30 on a waiting list and must refuse services to an average of five youths daily. Many calls are received outside of our geographical area requesting information about our program. Some of these result in client referrals.

1. Project Phoenix has documented the need for room to serve forty youth on a daily basis. Presently the facilities can accomodate no more than eighteen youth. No office space to house research is abailable.
2. The building used as a dormitory recently caught fire because of an electrical difficulty.
3. All of the buildings are unattractive and not conducive to positive treatment.
4. The present buildings are located on a small piece of land that provides no room for many leisure/work activities that would enhance therapy.
5. The present buildings are adjacent to the Kyle Jail, a location that links the Center to negative factors.
6. There is not enough room for individual and group counseling not staff consultations to be provided in a confidential manner.
7. No room presently exists to house families of youth who may have traveled long distances to attend family counseling. The village of Kyle itself has no motels or housing facilities. Families who do come to visit a young family member usually have to stay in motels that are up to fifty miles away.
8. There are no facilities available to house youth who need to be under constant observation.
9. No facilities presently exist to provide intensive after-care. Many youth who successfully complete the treatment program, return to substance abuse as soon as they return to negative environments.
10. Equipment for office, kitchen, dormitories and program is severely inadequate. Replacement and additional equipment is needed.
11. Transportation at present consists of one van which is often in-operable, making it impossible to take children to A.A. meetings, educational functions, recreational activities, or workshops. The van is dangerous because of breakdowns in cold weather and illegal for transporting the number of clients we have here (18).

STAFF

Project Phoenix has eleven employees, all are Native American. Titles, job descriptions and number of positions are:

PROJECT DIRECTOR (1) - The Project Director is responsible for overall administration of the project including; implementation and evaluation of program objectives/activities, supervision of staff; staff training; day-to-day project administrative activity, public relations; program reporting and other duties required to conduct successful programming.

ADMINISTRATIVE ASSISTANT (1) - The Administrative Assistant is responsible for clerical duties, typing, filing, bookkeeping, and office management functions.

DATA COORDINATOR (1) - The Data Coordinator is responsible for compiling data received from counselors, reporting information to Indian Health Service, gathering information from clients who have exited the program and are on out-patient status; and other duties as assigned by the Administrative Assistant.

COUNSELOR I (1) - The Counselor I is responsible for: establishing daily schedules of activity; shift schedules; implementing daily schedule while on tour-of duty; maintaining client caseloads; conducting staffing; drafting reports and other duties as assigned by the Administrative Assistant.

COUNSELOR II's (5) - The Counselor II's are responsible for implementation of daily schedules and other duties as assigned by Counselor I

COOK (1) - The Cook is responsible for ordering and storing of foods and supplies; planning meals; cleaning, preparing meals and sanitary maintenance of the kitchen and dining areas; and is reponsible to the Project Director.

NIGHTWATCHPERSON (1) - The Nightwatchperson is responsible for securing facilities and premises; reporting activities and incidents in the daily log to the Project Director; as appropriate.

OGLALA SIOUX TRIBE

PROJECT PHOENIX

FY 85-86

SALARIES

PROJECT DIRECTOR	$9.83 X 80 HRS. X 26	$ 20,446
ADMINISTRATIVE ASSISTANT	6.74 X 80 HRS. X 26	14,019
DATA COORDINATOR	5.61 X 80 HRS. X 26	11,669
COUNSELOR IA	6.74 X 80 HRS. X 26	14,019
COUNSELOR IIA	5.61 X 80 HRS. X 26	11,669
COUNSELOR IIB	5.61 X 80 HRS. X 26	11,669
COUNSELOR IIC	5.61 X 80 HRS. X 26	11,669
COUNSELOR IID	5.61 X 80 HRS. X 26	11,669
COUNSELOR IIE	5.61 X 80 HRS. X 26	11,669
COOK	5.46 X 80 HRS. X 26	11,356
NIGHTWATCH	4.37 X 80 HRS. X 26	9.090
TOTAL SALARIES		$ 141,294
FRINGE BENEFITS @ 17.3%		24,444
TOTAL FRINGE BENEFITS & SALARIES		$ 165,738

TRAVEL

(4) TRIPS TO ABERDEEN: $125.00 per person X 2 X 4 MILEAGE TO & RETURN	$ 1,595
VAN MAINTENANCE & FEUL: $200.00 per month X 12	2,400
CLIENT RECREATION & ACTIVITIES: $80.00 per month X 12	960
STAFF MILEAGE: $233.33 per month X 12	2,800

TRAINING

USD - VERMILLION ST. MARY'S ADOLESCENT TREATMENT CENTER BLACK HILLS TRAINING CENTER SIOUX SAN ALCOHOLISM PROGRAM $950.00 for 2 Staff X 8	$ 7,600

CLIENT CARE

FOOD & PERSONAL ITEMS FOR AN AVERAGE OF 15 CLIENTS $3.00 per day X 365 days (includes soap, shampoo, toothpaste & other personal items)	$ 16,425

OTHER COSTS

DORMITORY SUPPLIES (LINEN)	$ 1,000
SUPPLIES (OFFICE)	1,500
ELECTRICITY	2,500
LP GAS/HEAT	4,200
WATER & SEWER	684
POSTAGE	528
TELEPHONE	3,000
MAINTENANCE (BUILDING)	2,000
EDUCATIONAL MATERIALS	500
EQUIPMENT REPAIR	2,000

OTHER COSTS CONTINUED

EQUIPMENT	$ 1,735
TOTAL DIRECT COST	$ 217,165
INDIRECT COST @18.7% LESS EQUIPMENT	40,285
TOTAL BUDGET FOR FY 85-86	$ 257,450

TIMETABLE CHART

ACTIVITY	COMPONENT	1st QTR.	2nd QTR.	3rd QTR.	4th QTR.	DATE REQUIREMENT FOR SPECIFIC ACTIVITY	RESPONSIBILTY
1. SHOW FILMS	PREVENTION	X	X	X	X	ONCE, MONTHLY	COUNSELORS
2. CONDUCT LECTURES/DISCUSSION		X	X	X	X	ONCE, MONTHLY	
3. CONDUCT EVALUATION			X	X	X	TWICE, MONTHLY	
4. TABULATE EVALUATION RESULTS					X	ONCE, MAY 31	
5. IDENTIFY DYSFUNCTIONAL AREAS WITH CONSULTATION FROM: A. COURT B. SCHOOL C. FAMILY	INTERVENTION	X	X	X	X	A) ONCE, AT ENTRY: B) ONCE, AT ENTRY & AS NEEDED C) ONCE, AT ENTRY & AS NEEDED	COUNSELORS
6. CONTACT YOUTH		X	X	X	X	ONCE, OR UNTIL CONTACT IS MADE	COUNSELOR
7. REVEAL BEHAVIOR PATTERNS & OTHER CONFRONTATION ACTIVITIES		X	X	X	X	ONCE, DURING PRIMARY PHASE AND AS NECESSARY THEREAFTER	COUNSELOR
8. RECOMMEND POSTIVE ALTERNATIVES IN CREATIVE EXPRESSION, RECREATION, AND LEISURE-TIME EXPERIENCES.		X	X	X	X	ONCE, DURING PRIMARY PHASE AND THEREAFTER, AS REQUIRED	COUNSELOR
9. PROVIDE EXPOSURE TO UTILIZATION OF TRADITION/CULTURE THROUGH LECTURES AND FILMS		X	X	X	X	SAME AS ABOVE	

ACTIVITY	COMPONENT	1st QTR.	2nd QTR.	3rd QTR.	4th QTR.	DATE REQUIREMENT FOR SPECIFIC ACTIVITY	RESPONSIBILTY
10. PROVIDE EDUCATIONAL ADVANCEMENT EXPERIENCES; GED, HUMAN RELATION SKILLS	INTERVENTION	X	X	X	X	ONCE, DURING PRIMARY PHASE AND THEREAFTER AS REQUIRED	COUNSELORS
11. CONDUCT SMALL GROUP THERAPY SESSIONS, INCLUDING ALCOHOLIC ANONYMOUS (A.A.)	TREATMENT	X	X	X	X	WEEKLY	COUNSELORS
12. CONDUCT STAFFINGS		X	X	X	X	BI-WEEKLY & UPON PROGRAM EXIT	COUNSELORS
13. CONDUCT INFORMATIONAL LECTURES, FILMS, DISCUSSIONS INCLUDING PHYSICAL, SPIRITUAL,PSYCHOLOGICAL ASPECTS AS THEY RELATE TO ALCOHOL/DRUG TREATMENT		X	X	X	X	DAILY	COUNSELORS
14. RECOMMEND READING LIST AND OTHER RESOURCES		X	X	X	X	ONCE, DURING THE PRIMARY PHASE	COUNSELORS
15. PURSUE THE DEVELOPMENT OF FAMILY SUPPORTS SYSTEMS	FOLLOW-UP		X	X	X	ONCE, ONE MONTH AFTER EXITING TREATMENT THEN ON A DECREASING BASE	COUNSELORS
16. MAKE PROVISIONS FOR PERIODIC CLINICAL VISITS			X	X	X	ONCE, NINTY DAYS AFTER EXITING PROGRAM AND GRADUAL PHASE OUT THEREAFTER	DATA COORDINATOR
17. ELICIT FEEDBACK IN THE FORM OF QUESTIONAIRES TO DETERMINE CLIENT STABILITY AND CONTINOUS PROGRESS			X	X	X	ONCE, ONE YEAR AFTER PROGRAM EXIT	DATA COORDINATOR

ACTIVITIES MANAGEMENT CHART

The chart below is intended for management use. That is, the date of accomplishment, number of clients served, and degree of success will be recorded and analyzed by the Project Director to insure that activity is adequate and on-schedule.

PREVENTION COMPONENT	DATE ACCOMPLISHED	NUMBER SERVED	DEGREE OF SUCCESS	INTERVENTION COMPONENT	DATE ACCOMPLISHED	NUMBER SERVED	DEGREE OF SUCCESS	TREATMENT COMPONENT	DATE OF ACCOMPLISHED	NUMBER SERVED	DEGREE OF SUCCESS	FOLLOW-UP COMPONENT	DATE OF ACCOMPLISHED	NUMBER SERVED	DEGREE OF SUCCESS
ACTIVITY 1.				ACTIVITY 5.				ACTIVITY 11.				ACTIVITY 15.			
ACTIVITY 2.				ACTIVITY 6.				ACTIVITY 12.				ACTIVITY 16.			
ACTIVITY 3.				ACTIVITY 7.				ACTIVITY 13.				ACTIVITY 17.			
ACTIVITY 4.				ACTIVITY 8.				ACTIVITY 14.							
				ACTIVITY 9.											
				ACTIVITY 10.											

DRUG USE AMONG STUDENTS AT LITTLE WOUND:

A REPORT OF A SURVEY

SPRING, 1984

Prepared by:
Western Behavioral Studies
Department of Psychology
Colorado State University
Fort Collins, Colorado

INTRODUCTION

Drug use by young people is a sensitive topic in most communities. Some people try to ignore it and say that very little drug use is going on. Other people become very alarmed and tend to exaggerate the level of drug use in order to give it attention. It is not often that accurate numbers are available so that the real size of the problem, and possible solutions, become clear. Fortunately, the schools on the Pine Ridge Reservation have chosen not to ignore the issue and have cooperated in a series of drug and alcohol use surveys. These schools have worked with Western Behavioral Studies at Colorado State University to administer a questionnaire to their students in the 4th through 12th grades. The first group of surveys were given in the schools in the fall of 1980, a second in 1982 and this third one in 1984.

This report covers the results of the most recent survey. This third survey should make it possible to see if any important changes in drug use have taken place on the Reservation since the first survey was given in the fall of 1980.

Drug and alcohol use are community problems and all parts of the community must work together toward a solution. Although the information contained in this report was collected in the schools, this does not mean that the schools are primarily responsible for any problems that may be identified. The Pine Ridge schools have been and will continue to be a valuable partner in the work of drug abuse intervention; however, it would be a serious mistake to single out the schools as being the cause of drug problems. The schools only provide access for surveying young people and a convenient way of reporting about the adolescent population of the Pine Ridge area. It is up to all parts of the community, especially the parents, to work toward effective solutions.

In the past drug and alcohol use were considered separate problems. Some people were thought to be more likely to use alcohol, while others were thought to have only drug problems. In the last few years we have found, at least for young people, that the two problems are not distinct. Drugs and alcohol have much the same meaning for young people and are often used together. Therefore, in this report when the term drugs is used it will also include the use of alcohol.

The report contains two major sections. Section I is the largest and will be an overall report for all of the Pine Ridge schools combined. In Section I there will be 1) background material which describes the survey, 2) a discussion of the recent adolescent results (grades 7-12) and a comparison with the 1980, 1982 and 1984 results, 3) a comparison of the adolescent results with a national, non-Indian survey, and 4) a description of the results of the 1984 children's survey (grades 4-6) and a comparison of the 1980, 1982 and 1984 results. In addition, several appendices provide materials that will help in understanding drug use at Pine Ridge.

Section II is a report of the results for each individual school. Section II will be different for every school and each school will receive only its own results. The schools alone may decide who they will share their results with. No information will be disseminated from Western Behavioral Studies without explicit permission from the tribe and/or the school.*

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* Only Section I will be sent to those with a legitimate interest in general conditions at Pine Ridge. Again, Western Behavioral Studies will not disseminate these results further without tribal permission.

Section III, Factors Related to Drug Use, discusses in general why many Indian youth use drugs and alcohol.

Appreciation is expressed to Mr. Emanuel Moran, Agency Superintendent for Education at Pine Ridge South Dakota for his assistance in this project. We would also like to thank the principals, teachers and other cooperating staff at the following schools:

- Pine Ridge (Oglala Community School)
- Crazy Horse
- Batesland
- Wolf Creek
- Red Shirt
- Rocky Ford
- Porcupine
- Loneman
- Manderson
- American Horse (Allen)
- Red Cloud
- Little Wound
- Our Lady of Lourdes

SECTION I

SURVEY RESULTS FOR ALL
PINE RIDGE SCHOOLS 1980-1984

BACKGROUND

What is the Survey Like?

Two forms of the survey were given in the Pine Ridge schools -- one form was given in the 4th-6th grades and the other in the 7th-12th grades. The children's form (grades 4-6) contained 128 questions and the adolescent form contained 172 questions. Each question had several possible answers which could be marked by the student. The surveys were completely anonymous and many safeguards were used to make sure that no individual student's answers could be identified.

The survey had items that asked about drug use and about those things that might be related to drug use. After a few questions that asked about background information (age, sex, etc.), a large group of items measured the uses of alcohol, cigarettes, and nine other commonly used drugs (only alcohol, tobacco, marijuana, inhalants, and "pills" were asked about on the children's survey). Students were asked how often, how much, and when they used different drugs. After the drug use items were items that asked about their reasons for use, whether friends or family encouraged use or tried to stop it, and how harmful they thought drugs were. The final questions asked about personal adjustment (depression, shyness, etc.), school adjustment, and how students felt about their future.

Survey Accuracy

One of the first questions that should be asked about any survey is "How accurate is it?" or "How much confidence can we place in the results?" There are many things that can go wrong when using a survey and a good survey must take as many of these into account as possible. The next three sections will cover the major problems of survey accuracy.

How was the Survey Constructed? The survey used was the product of over eight years of development in working specifically with Indian populations. The original set of items were taken from surveys that had been used in various parts of the country. Over time, these items were changed to make them even more accurate: some items were dropped, and new items were added to clarify areas that were unclear. Through much experience and numerous statistical analyses the survey has been gradually improved and made appropriate for Indian populations. Over 20,000 students have taken this survey.

Who Took the Survey at Pine Ridge? The surveys were given in one regular class period during the school day to all 4th-12th graders in the district. Every student in class at that time took it. Those who were absent from class on the day of the survey are not included in these results. It is also important to realize that school dropouts or those who attend school sporadically were not surveyed. Most people agree that school dropouts probably have higher rates of drug and alcohol use; therefore, the actual rates of use for all school aged young people in Pine Ridge might be higher than those reported here.

The actual number of students surveyed are provided in Table 1:

TABLE 1

NUMBER OF STUDENT SURVEYS AT PINE RIDGE IN 1984

	Number Surveyed	Number Enrolled	Percent
4th-6th grade	756	931	81%
7th-12th grade	1092	1409	78%
TOTAL	1848	2340	79%

What Evidence is There for Survey Accuracy? Some young people may not take surveys seriously and will not answer all the questions; some may try to distort their answers and either exaggerate or minimize their drug use; still others may try to "be funny" and give strange or contradictory answers. Since these things cannot be entirely avoided, steps must be taken to determine how seriously they affect the survey results.

A number of things were done to check the accuracy of the survey given at Pine Ridge. First, several questions were asked about the use of each drug. If a student answered these inconsistently, for example saying that they never tried a drug and then saying that they use it on weekends and holidays, the survey was not used to calculate overall results. On the Pine Ridge adolescent survey only 3.7% of students responded inconsistently.

Another way of checking for inaccuracies is to ask students about "fake drugs" -- drugs that really do not exist. At Pine Ridge only 1.5% of the youngsters said they had used the fake drugs asked about on the survey. Some of these may have actually been trying to exaggerate their level of drug use. On the other hand the names of the fake drugs could have been confused with real drugs the students had actually taken. Other students may have thought, "I've taken so many different drugs, I surely must have taken these." All in all very few students tried to exaggerate their drug use.

Finally, the last two questions on the survey ask students how honest they have been in answering the questions about their drug and alcohol use. About 95% said they were "very honest". Of the remainder, on both the childrens and the adolescent survey there was an even split between those over and those under estimating their use.

In sum, yes there were some inaccuracies on the survey -- this is to be expected. However, all of the evidence indicates that the errors were small and a great deal of confidence can be placed in the results of the survey.

Organization of the Report

The next section of the report will cover the results of the surveys given in the 7th-12th grades. These grades are combined at this point because there are two other groups of 7th-12th graders with which Pine Ridge can be compared. These comparisons will help put the situation at Pine Ridge in perspective and give some idea as to whether or not the use of drugs and alcohol is better or worse than in other places.

After the adolescent results are presented the results for the 4th-6th grades will be discussed.

Some people may be interested in seeing the results separately for the intermediate school (grades 7 and 8) and for the high school. These will be presented in a separate report.

DRUG USE AMONG THE 7TH-12TH GRADERS
IN THE PINE RIDGE SCHOOLS

There are many ways of answering the question, "How many of our young people are using drugs and alcohol?" That one question is really too simple and has many answers depending on what information we are after. Some of the possible meanings are:

1. How many students have ever used a particular drug?
2. How many are using that drug now?
3. How often are they using it?
4. How much of it are they using?
5. How many are using several different drugs?

Each of these questions would require different information.

We will start with the simplest level and report the number who have "ever used" drugs. For each drug the survey asks, "Have you ever used (name of drug)? Now this question includes any amount of use, at any time in one's life. A person answering yes to this question about marijuana may have had a single puff two years ago. Another person answering yes may be using marijuana every day. These two people are very different but would both be counted in the "ever used" percentage. This drawback to the ever used percent should be kept in mind whenever it is being looked at.

On the other hand, this number can be very useful in seeing how common the use of a drug is and how much pressure a young person is under to try a drug. To use an extreme example, if 70% of the students in a school have tried marijuana -- even if many have only used it once -- you can be pretty sure it is readily avaiable and that there is quite a bit of pressure on every youngster to use marijuana. However, if only 5% have ever tried it, it would suggest the drug was not readily available and there was little encouragement to use it. Another value of the "ever used" type of question is that it allows us to compare one group of students with another. Most drug surveys include an "ever used" question so we can compare Pine Ridge with other places in the country.

Table 2, on the next page, shows the "ever used" percentages. It represents those students who answer yes to the question "Have you ever tried (name of drug)?" Keep in mind that the percentage can include both people who only tried a drug once and those using it regularly. The results are given for each year, 1980, 1982, and 1984.

Several important results are seen in the table. First, in 1984, alcohol, marijuana, tobacco, inhalants and stimulants continued to lead the list of drugs this group has tried. There are slight increases in alcohol and inhalant use since 1982 but not enough to be important. The slight decrease in stimulants may reflect a national trend toward less stimulant use, but again the difference is too small to be confident of its meaning.

A few drugs are showing a very slight increase from 1982 to 1984 (e.g. sedatives, cocaine and hallucinogens) but they are still lower than the peak reached in 1980.

The most important result seen in Table 2 is that the overall level of exposure to drugs remains quite high among the Pine Ridge students and is still cause for great concern. The one encouraging note is that drug use seems to be leveling off and in some cases may even be dropping slightly. It remains to be seen if this may be the beginning of a long term downward trend.

TABLE 2

LIFETIME USE OF DRUGS AND ALCOHOL BY ALL PINE RIDGE 7TH-12TH GRADERS FOR 1980, 1982, AND 1984

	1980	1982	1984
Alcohol	80.7%	79.5%	82.1%
Marijuana	73.1%	71.9%	71.3%
Tobacco	63.9%	60.0%	55.7%
Inhalants* (excluding cocaine)	27.1%	28.4%	30.5%
Stimulants (speed, uppers)	20.6%	25.5%	24.0%
Sedatives (downers, barbiturates or methaqualone)	8.5%	4.1%	6.6%
Tranquilizers (Librium, Valium, etc.)	6.8%	3.7%	4.2%
Heroin	3.9%	2.5%	2.6%
Cocaine	11.1%	6.4%	8.5%
PCP	6.7%	4.4%	4.5%
Hallucinogens (LSD, mushrooms, etc.)	10.9%	6.1%	7.1%

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* May be low due to known underreporting of Amyl and Butyl Nitrites.

Use in the Last Two Months

For several drugs information is available on the amount of recent use. This information gets a little closer to the question of whether a drug is being used now. Data in Table 3 provide the percent of students who have used a drug during the last two months. Note this information still does not indicate how much or how often a drug is being used.

TABLE 3

PERCENT OF PINE RIDGE STUDENTS WHO HAVE USED
DRUGS WITHIN THE LAST TWO MONTHS FOR 1980, 1982, AND 1984

	1980	1982	1984
Alcohol	58.9%	60.3%	59.4%
Marijuana	60.2%	54.5%	50.1%
Inhalants	6.2%	6.1%	15.3%
Stimulants	11.5%	9.1%	9.7%

Recent alcohol use is pretty stable over the years but recent marijuana use has dropped about 5% a year since 1980. Note however the increase in the use of inhalants. Since 1982 this percentage has more than doubled.

Daily use of marijuana has become an important indicator of drug misuse within the last few years. Because the chemicals in marijuana are gradually stored in the body, regular use can cause a serious buildup over time. In 1980 13.8% of the Pine Ridge students said they used marijuana daily, in 1982 this percent had dropped to 10.6% and in 1984 was 9.3%. This is an important finding and shows Pine Ridge is following the national trend of lower daily use of marijuana. It is notable that while daily use of marijuana seems to be decreasing, this is still a large number of students to be using a drug on this regular of a basis.

Table 3 shows that nearly two-thirds of all Pine Ridge students used some alcohol in the past two months. How much did they use? One survey question asked how often they had been drunk in the last two months. The response was that 23% had been drunk once or twice, 6% had been drunk three to nine times and 1% had been drunk ten or more times. These figures are nearly the same as they were two years ago so there is little sign that heavy drinking is tapering off much. Another question on the survey asked the students how many times they had ever been drunk enough in their life to pass out -- 20% said this had happened once or twice and 5% said three or more times. This seems like very heavy drinking for 7th-12th grade young people.

Drug Use Patterns

The information given so far is helpful in understanding the general level of drug use among this group of students. For example, it is very clear that alcohol and marijuana are widespread, easy to get and routinely used by a large number of students. However, a lot of young people do not use only one or two drugs, some use several drugs and use them at the same time. Some students use drugs, or combinations, quite often while others may do so only occasionally. A number of students may use only one drug, but use it regularly and in heavy amounts. What we will do next is to describe the many patterns of drug use that students commonly engage in. In the last section we talked about individual drugs and the percent of their use. We will now describe groups of students and the actual ways in which these students use drugs.

At Pine Ridge seven basic patterns of drug use were detected. The patterns were found by examining the answers to the drug use questions in order to find students who used the same drugs in about the same way. The patterns are shown in Table 4. The groups are listed in order of the seriousness of their drug involvement.

Also shown in Table 4 are the percent of other Indian students in each of the drug use types. This data is taken from a large sample of Indian students from various parts of the country.

TABLE 4

PERCENT OF PINE RIDGE ADOLESCENTS
IN EACH DRUG USE TYPE

	1980	1982	1984	Other Indians 1982-83
1. Polydrug Users	8.0%	4.1%	4.7%	3.9%
2. Stimulant Users	9.1%	7.9%	11.2%	6.2%
3. Periodic Drug Users	6.4%	7.5%	7.0%	9.0%
4. Marijuana & Alcohol Users	36.0%	35.7%	33.4%	33.9%
TOTAL OF THE FIRST FOUR GROUPS	59.5%	55.2%	56.3%	53.0%
5. Drug Experimenters	17.4%	20.5%	19.5%	21.1%
6. Light Alcohol Users	3.5%	4.0%	3.2%	4.7%
7. Negligible Users	18.3%	20.3%	20.9%	21.2%

Each of the drug use types is described in Appendix A. It is important for the reader to become familiar with these descriptions so that the percentages in Table 4 can be correctly interpreted.

One way of looking at Table 4 is to combine the first four groups. Based on the descriptions of the groups in Appendix A anyone in the top four groups could be considered to be at some risk due to their use of drugs. The risk could be either physical such as getting in an accident or psychological such as becoming addicted and ignoring school or other important parts of life. Nearly 57% of the Pine Ridge 7th-12th graders are in these top four groups. This is down just slightly from 1980 when Pine Ridge was first surveyed. Hopefully this trend will continue, but for now it is important to realize that over half of all young people at Pine Ridge who are still in school are in some danger due to their use of drugs.

When compared to the other Indian young people a couple of important differences are evident. There are a few more Pine Ridge students in the Polydrug Use group and considerably more in the Stimulant users group. It appears that amphetamines and cocaine, used in combination with other drugs, are quite common at Pine Ridge.

Combining the first four groups shows that Pine Ridge has a few more students in the more serious drug types than among other Indian groups.

One question that may occur in looking at the drug use types is why isn't there a heavy alcohol use group. Previous information would lead us to believe that a number of Pine Ridge students may be using alcohol quite heavily. The answer is really rooted in the nature of adolescent drug use. There are quite a few Pine Ridge students who use a lot of alcohol, but, these same people are also using other drugs pretty heavily. Because of this they will be classified in one of the top four groups in Table 4. This is an important finding --young people using a lot of alcohol are probably also using some other drugs regularly. It is no longer possible to say that, for young people at least, drugs and alcohol are separate problems. They go together and probably have many of the same causes.

Another important thing to be learned from Table 4 is that quite a few Pine Ridge students are not involved with drugs. One fifth of them are essentially drug and alcohol free (Type 7) and another one-fourth will probably never experience any problems due to drug and alcohol use (Types 5 & 6).

In reading the descriptions of these groups, try to think of ways in which these young people can be helped. After all, the major value this survey has is in finding ways to help those adolescents who may be having trouble because of the use of drugs. Young people in each of these patterns need different types of help. It is widely accepted, for instance, that education about the danger of drugs has little effect on students who are already heavily involved with several drugs -- they already know a lot about drug effects and tend to "tune out" when educational lectures or materials are presented. On the other hand, students who are starting to experiment with different drugs might benefit a great deal by being factually informed about what the possible harmful effects are. Unless these kinds of differences in drug use types are recognized, we are likely to make mistakes in our efforts to help young people.

It would be helpful if we knew more about students in each of the patterns in Table 4 than just how they use drugs. How are they doing in school? How do they feel about themselves? What level of family support do they have? What are their friends like? How do they feel about their future? If we know the patterns of drug use and some of the other important personal and social problems faced by these students we could provide a great deal of help. Some of the things which have been found to be related to the drug use patterns are discussed in Section III.

COMPARISON WITH A NATIONAL SAMPLE

It is sometimes helpful to know how one location compares in drug use rates with the rest of the country. A comparison may give some idea of special problems in one place and it can also give a better idea as to the overall size of the drug problem.

It is always a little bit risky to compare two different surveys. There may be differences in the times they were given, the wording of the surveys, the way the surveys were given and so forth. No two surveys are exactly alike, but if we are careful in our interpretation, it is possible to draw some helpful conclusions. It should be remembered that differences of just a few percentage points are probably not meaningful. Table 5 on the next page compares the 1984 Pine Ridge 12-17 year olds with a national sample of 12-17 year olds surveyed in 1982. More recent published national data are not available, but despite the time difference the comparison should be informative. National use rates rarely change more than a percent or two a year so a two year time difference should not affect comparisons very seriously.

The table shows the Pine Ridge students to have more exposure to alcohol, marijuana, tobacco and inhalants than the national sample. The rate of use of marijuana is especially high and again shows that marijuana use is very common among the Pine Ridge students. Inhalant use is over triple the national figure and may be signaling a signifiant problem for Pine Ridge young people. The high rate of stimulant use is also worth noting. Stimulant use has increased rapidly nationwide and the same thing appears to be happening at Pine Ridge.

It is clear that all drugs used nationally are available at Pine Ridge and some drugs are used much more widely. It is encouraging to note however that Pine Ridge is showing similar use rates for some drugs such as tranquilizers and sedatives. This was not true in 1980 when Pine Ridge was showing much higher use rates than national figures for nearly all drugs.

TABLE 5

PERCENTAGE OF STUDENTS HAVING
EVER USED DRUGS

	1984 Pine Ridge Total (12-17 year olds)*	1982 National Sample (12-17 year olds)**
Alcohol	81.1%	65.3%
Marijuana	70.0%	27.3%
Tobacco	54.6%	49.9%
Inhalants (excluding cocaine)	30.5%	9.8%***
Stimulants (speed, uppers)	22.6%	6.5%
Tranquilizers (Librium, Valium, etc.)	4.0%	4.8%
Sedatives (downers, barbiturates or methaqualone)	5.7%	6.1%
Cocaine	7.1%	6.9%
Hallucinogens (LSD, mushrooms, etc.)	5.7%	5.2%
PCP	3.9%	****
Heroin	2.5%	0.5%

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* These numbers will be slightly different than those found in Table 2 because the numbers in Table 5 are for the 12-17 year olds only.

** This data is from the National Household Survey on Drug Abuse conducted by the George Washington University Social Research Group.

*** This is for a 1979 sample.

**** Not available.

CHILDREN'S DRUG USE

So far we have seen the extent of drug use among the 7th-12th graders who attend the Pine Ridge schools. It is important to now ask, "How young does this use start?" If it is present among adolescents, the roots must begin at an earlier age.

In order to gain some understanding of early drug and alcohol use, a survey was also given to the Pine Ridge 4th-6th graders. The survey was a shorter and simpler version of the one given to the older students but much the same information was gathered. Fewer drugs were specifically asked about on the children's survey to avoid the possibility of suggesting drugs to those not already familiar with them. The drugs included in the survey are alcohol, cigarettes, inhalants, marijuana and "pills".

The results of the chidren's survey will be described in much the same way as for the adolescents. We will first look at the levels of use of particular drugs and then examine drug use patterns found among elementary school children. The young people of Pine Ridge will be compared with a 1982 sample of other Indian youth. National non-Indian data for this age group is not available.

Ever Used

Table 6 shows the 1980, 1982 and 1984 percentages for lifetime use of the listed drugs. It can be seen from Table 6 that lifetime drug use among the students in the 4th-6th grades at Pine Ridge has increased significantly since 1980 for each drug. This increase in drug use is exactly opposite of what has occurred among older adolescents. Drug use among students in the 7th-12th grades at Pine Ridge has stabilized in most drug categories and slightly decreased in others. The importance of the increase in the "ever used" percentages will become clear as we next look at drug use patterns.

TABLE 6

PERCENT OF PINE RIDGE AND OTHER INDIAN 4TH-6TH GRADE STUDENTS WHO HAVE EVER USED DRUGS

	Pine Ridge			1982
	1980	1982	1984	Other Indian Youth
Alcohol	23.3%	22.9%	33.1%	24.4%
Cigarettes	23.2%	30.0%	35.7%	31.4%
Inhalants	12.1%	14.6%	19.2%	14.3%
Marijuana	17.1%	25.2%	31.5%	23.8%
Pills	8.7%	7.2%	10.0%	7.1%

Children's Drug Use Types

Recall from the discussion of adolescent drug use that use rates for a single drug do not give the best description of how young people are using drugs. Of more interest are the patterns or combinations of drug use. Patterns of drug use occur among younger children although they are different than those found among adolescents. The types and the percent of students in each children's type are shown in Table 7. The descriptions of the children's types are found in Appendix B and again the reader is encouraged to become familiar with these. This is especially important since in the children's types there is much less drug use than in the adolescent types and it is easy to confuse the two.

For instance, younger children, such as those in the 4th-6th grades, are not usually exposed to the whole range of drugs. Most of their drug use consists of alcohol, marijuana, and inhalants. The Child Polydrug pattern, therefore, does not include use of heavier drugs. It consists of using both marijuana and inhalants on a regular basis (and usually alcohol as well). Similarly, the other patterns, while they may parallel the adolescent groups, do not include extensive drug use, nor use of heavier drugs. The Drug Experimentation group, for example, contains those who may have only tried marijuana or inhalants just once.

TABLE 7

THE PERCENT OF 4TH-6TH GRADE STUDENTS IN EACH OF THE DRUG USE PATTERNS

	Pine Ridge			Other Indian
	1980	1982	1984	1982-83
1. Child Polydrug	3.3%	8.0%	7.2%	7.9%
2. High Drug Involvement	5.7%	6.9%	8.2%	7.7%
3. Light Marijuana	6.1%	6.9%	10.4%	6.2%
4. Alcohol	4.7%	8.7%	7.8%	9.1%
5. Drug Experimentation	18.6%	11.4%	19.9%	12.5%
6. Negligible Use	60.2%	56.2%	46.5%	56.6%

The higher "ever used" rates seen in Table 6 are clearly reflected in the increase in the drug use patterns shown in Table 7. Since 1980 students in each drug use category have doubled. In 1984, youngsters in the Child Polydrug and Alcohol Use pattern have decreased but this has been more than compensated for by the increases in the other drug use patterns. Of particular importance are the students entering the Drug Experimentation category and the steadily decreasing Negligible Use pattern.

In 1982, it was suggested by researchers at Western Behavioral Studies that the increases in the drug use rates in 1982 of younger children was due to these youngsters picking up a drug using "culture" experienced by their older peers earlier in the 1980's. It was indicated that there is a general trend in drug use where drug use starts with older youth, and finally expands downward to reach younger children. It was also suggested that this downward expansion --a "ripple effect" -- would "run its course in two to three years, at which point polydrug use of the younger ages will also taper off." These explanations probably still hold true for the continuing drug use increases in 1984 among these young children.

It is possible that the decreases in the Child Polydrug rate is a result of drug use reaching the bottom limit of the downward expansion. However, this expansion does not appear to have been reached in all other drug use patterns. Although the older adolescents drug use rates appear to have stabilized, and in some instances are decreasing, it is still possible that the "ripple effect" has not run its complete course.

Drug use at the national level and among other Indian youth is decreasing. Thus, it is probable that drug use among older adolescent Pine Ridge students will also begin a downward trend. Based on current drug use data, however, as the younger people (4th-6th graders) grow older we may once again see an increase in drug use or at least little reduction in the already very high rates. The pattern of lower drug use among the adolescents will work its way downward but very slowly. This downward expansion could happen much more quickly if effective intervention programs were implemented for all youngsters but particularly for those comprising the Drug Experimentation and Negligible Use patterns. These two groups, which represent about 67% of the total, are most apt to benefit from such programs.

SUMMARY AND CONCLUSIONS

After reaching peak in 1980, drug use among adolescents on the Pine Ridge Reservation may be leveling off. While this is in part good news it must be realized that the plateau is extremely high. More than half of all the 7th-12th grade students are now using drugs and alcohol in ways that are putting them in some type of danger. The danger may be physical or it may be that drugs and alcohol are seriously disrupting the important psychological development that takes place during adolescence. A small group of students, around 5%, are heavily enough involved with drugs that they are risking becoming addicted.

Contrary to what was seen for the older students, drug use rates for elementary school students on Pine Ridge have been inreasing since 1980. It seems that the large surge in drug use seen at the older ages several years ago is now working its way downward. The amount of drug use is not especially heavy, but one third of these 4th, 5th and 6th graders have had some experience with alcohol, cigarettes or marijuana -- quite a few have used all three. Inhalant use has nearly doubled to now involve one in five students. These rates are exceptionally high for kids as young as nine, ten and eleven. It remains to be seen what will happen as these young people enter adolescence.

While the patterns of drug use are changing on Pine Ridge, they continue to show a tremendous need for interventions. The lives of a significant number of young people are being adversely affected -- there is a strong obligation to pursue prevention and treatment programs.

The dramatic increases in drug use at the elementary school are of special concern. Fortunately these young people are still at an age where they can be influenced by the adults in their community. It is worth repeating that all adults in the community, in particular the parents, must become involved in countering the problem of drug abuse. The schools have allowed us to collect information about students but this does not mean that the problems found are the responsibility of the schools alone. The young people of Pine Ridge must see that the entire community is concerned about the use of drugs and is making a strong effort to counter that use.

SECTION II

DRUG USE AT LITTLE WOUND

Introduction

This part of the report will describe the results of a drug survey conducted at Little Wound in the spring of 1984. Several other Pine Ridge schools also participated in this project and will receive their individual results. The overall results for all schools are presented in Section I of this report Survey Results For All Pine Ridge Schools 1980-1984. Section I presents a complete description of the survey process and a detailed explanation of the meaning of the numbers to be presented here. It is important that Section I be read before trying to interpret individual school results.

On the following pages several types of information will be provided. First are the results of the adolescent survey including the "ever used" percents and the classification of students by drug use types. Differences between 1980, 1982 and 1984 will also be discussed.* Next will be a comparison of the results from each individual school with a national, non-Indian sample of 12-17 year old adolescents. This should give some idea of the relative size of the drug problem at Little Wound. (The national sample data was taken specifically from 12-17 year olds.) Since it was necessary to restrict the comparison of each invididual location and the Pine Ridge composite to this age range, Tables A and C will differ slightly.

The last part of Section II presents the results of the children's survey (grades 4-6). Again, comparisons will be made with earlier data when available. Where trends are evident they will be discussed and possible implications for interventions will be pointed out.

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* At a few locations 1980 data are not available.

Adolescent Survey at Little Wound High School

Table A shows the percent of Little Wound adolescents who have ever used the listed drugs. This year's results are compared to 1980 and 1982 and to the average of all Pine Ridge schools in 1984.

With only one exception, the Little Wound students appear to be using more alcohol and drugs in 1984 than they did in 1982. This follows a general decrease between 1980 and 1982. These uniform fluctuations may well be a function of age. The low point in drug use in 1982 may be correlated with a slightly younger age for that sample (it is thought that younger students use less drugs). At any rate, the Little Wound students are more exposed to all alcohol and drugs in 1984 than they were in 1982.

The one exception to the higher ever used rate is for stimulants. Stimulant use on Pine Ridge in general has decreased slightly in the last few years and the Little Wound students may be following the same pattern. Moreover, stimulant use nationally shows a downward trend.

Comparison with the overall Pine Ridge sample shows that 1984 Little Wound students have similar drug use rates. This is contrary to 1982 when Little Wound students showed lower rates. This certainly should be an area of concern, although again the slightly older age may account for this.

The patterns of drug use have also fluctuated slightly since 1980 as can be seen in Table B. The data since 1980 does not indicate a clear trend for all drug use types and thus the results should be interpreted carefully. It is strongly recommended that the reader carefully review the total Pine Ridge analysis in Section I to get a better interpretation of the drug use situation on the Pine Ridge Reservation. It would clearly be wrong to assume that students at Little Wound are not exposed to or are not impacted by the overall drug use of students at Pine Ridge.

In Table B, the group labeled Stimulant Users has increased since 1982 despite a stable "ever used" stimulant rate. This may be explained by a pattern of more intense stimulant use (and perhaps increased cocaine use) by those using them and by the increase in marijuana use as seen in Table A (marijuana is also a preferred drug of this group).

When compared with a national sample* (Table C) the Little Wound adolescents use quite a bit more alcohol, marijuana, inhalants, stimulants, sedatives, PCP and heroin. Because the national data is dated in 1982 caution should be used during comparison. Some recent information however does indicate a lower usage of all drugs at the national level.

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* The best non-Indian comparison group is limited to 12-17 year olds. To make this comparison, all 18 year olds from Pine Ridge were eliminated.

TABLE A

PERCENT OF 7TH-12TH GRADE STUDENTS HAVING EVER USED DRUGS FOR ALL OF PINE RIDGE AND AT LITTLE WOUND

	Little Wound			Total Pine Ridge
	1980	1982	1984	1984
Alcohol	77.4%	73.7%	81.4%	82.1%
Marijuana	66.0%	59.1%	69.1%	71.3%
Tobacco	61.2%	54.2%	63.8%	55.7%
Inhalants (excluding cocaine)	19.4%	15.8%	26.7%	30.5%
Stimulants (speed, uppers)	24.8%	25.3%	23.0%	24.0%
Sedatives (downers, barbiturates, or methaqualone)	9.0%	3.5%	8.9%	6.6%
Tranquilizers (Librium, Valium, etc.)	4.6%	2.5%	4.0%	4.2%
Heroin	3.3%	2.9%	4.4%	2.6%
Cocaine	7.8%	6.0%	10.7%	8.5%
PCP	6.5%	3.6%	4.4%	4.5%
Hallucinogens (LSD, mushrooms, etc.)	11.0%	5.9%	6.7%	7.1%
Number Surveyed:	155	168	225	1092
Average Age:	15.0	14.6	15.1	14.7

TABLE 8

PERCENT OF 7TH-12TH GRADE STUDENTS IN EACH DRUG USE TYPE FOR ALL OF PINE RIDGE AND LITTLE WOUND

	Little Wound			Total Pine Ridge
	1980	1982	1984	1984
Polydrug Users	4.8%	5.6%	4.9%	4.7%
Stimulant Users	12.3%	6.2%	12.7%	11.2%
Periodic Drug Users	2.8%	4.9%	3.9%	7.0%
Marijuana & Alcohol Users	33.5%	29.6%	33.3%	33.4%
TOTAL OF THE FIRST FOUR GROUPS	53.4%	46.3%	54.8%	56.3%
Drug Experimenters	17.8%	16.0%	18.6%	19.5%
Light Alcohol Users	4.8%	6.2%	2.0%	3.2%
Negligible Users	23.2%	31.5%	24.5%	20.9%

TABLE C

PERCENTAGE OF STUDENTS HAVING EVER USED DRUGS

	Little Wound* 1984	National Non-Indian Sample of 12-17 year olds 1982**
Alcohol	80.2%	65.3%
Marijuana	67.0%	27.3%
Tobacco	61.9%	49.9%
Inhalants (excluding cocaine)	25.9%	9.8%***
Stimulants (speed, uppers)	20.4%	6.5%
Tranquilizers (Librium, Valium, etc.)	4.1%	4.8%
Sedatives (downers, barbiturates, or methaqualone)	8.1%	6.1%
Cocaine	7.6%	6.9%
Hallucinogens (LSD, mushrooms, etc.)	4.6%	5.2%
PCP	4.1%	****
Heroin	4.6%	0.5%

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* These percents will differ slightly from Table A since they are limited to 12-17 year olds.

** This data is from the National Household Survey on Drug Abuse conducted by the George Washington University Social Research Group.

*** This is for a 1979 sample.

**** Not available.

Children's Survey at Little Wound Elementary School

Table D shows the lifetime drug use ("ever used") percentages for the Little Wound 4th-6th grade students.

Since 1980 there have been increases in each listed drug with the exception of "pills". Note especially that marijuana use has nearly tripled. Little Wound appears to be following the exact same trend as other Pine Ridge schools where rates for all drugs are increasing for younger children. While the specific reasons for these increases are not known it is apparent that all drugs are readily available to Little Wound students and many are showing an increasing willingness to try the drugs.

In Table E, except for little change in the Polydrug pattern and a decrease in the Alcohol pattern, all drug use patterns show increases since 1982. The decrease in the Negligible Use pattern reflects the higher ever used rates (Table D) and indicates more students entering the drug using patterns. While the patterns in Table E are defined differently from the older adolescent pattern, students at Little Wound are using and many are experimenting with potentially dangerous drugs. These students are potential candidates for serious academic and personal problems in the future.

As was discussed in Section I: Children's Survey, it is highly possible that the increases in the "ever used" rates of the Pine Ridge 4th-6th graders may be due to the downward expansion of drug use experienced by the older adolescents in the late 1970's and early 1980's. This downward expansion may be reaching the bottom limit but it is doing so slowly. The next few years will be the most important with regard to drug use stabilization and decreases among the younger children. Certainly, effective support and intervention programs are needed to counteract the growing tendency toward drug use among these very young students.

TABLE D

PERCENT OF 4TH, 5TH AND 6TH GRADE STUDENTS
WHO HAVE EVER USED DRUGS

	Little Wound			Pine Ridge
	1980	1982	1984	1984
Alcohol	35.1%	26.1%	37.1%	33.1%
Cigarettes	20.3%	32.4%	40.0%	35.7%
Inhalants	12.2%	13.5%	17.3%	19.2%
Marijuana	12.4%	24.3%	33.3%	31.5%
Pills	8.2%	9.0%	8.7%	10.0%
Number surveyed:	98	111	105	756

TABLE E

THE PERCENT OF 4TH-6TH GRADE STUDENTS IN EACH OF THE DRUG
USE PATTERNS AT ALL OF PINE RIDGE AND LITTLE WOUND

	Little Wound			Total Pine Ridge
	1980	1982	1984	1984
1. Child Polydrug	0.0%	8.9%	8.3%	7.2%
2. High Drug Involvement	3.3%	3.0%	6.3%	8.2%
3. Light Marijuana	4.4%	5.9%	9.4%	10.4%
4. Alcohol	9.0%	13.8%	6.3%	7.8%
5. Drug Experimentation	16.9%	9.9%	16.7%	19.9%
6. Negligible Use	65.1%	58.5%	53.1%	46.5%

SECTION III

FACTORS RELATED TO DRUG USE

Throughout this report we have been able to describe in detail the different patterns of drug use among students. But what are some of the other personal qualities that may be associated with serious drug use? Or, what are the reasons a large number of young people do not become involved with drugs and alcohol in harmful ways? We cannot hope to answer these questions completely, but the drug use survey contained many items which will help us describe some of the personal and social characteristics of the drug use types. This kind of information can be especially useful in finding ways of helping those young people who may be in trouble due to drug and alcohol use.

As you read this material, you will find that it gets very complicated in some places. That is the nature of drug use. Although the factors will be discussed separately, they actually work together and produce very complicated patterns of behavior. In this discussion it will become quite clear that there is no single cause of drug use, nor is there a single cure.

Sex and Grade

The only major difference found between males and females is that there is slightly more males in the Polydrug User group. However, there are still quite a few females in this group so it would be a mistake to say that only males use drugs heavily. In fact, drug use seems to be distributed so evenly between males and females across all the groups that special programs aimed at males or females would be unnecessary.

As might be expected, the seriousness of drug use generally increases as students get older. The largest jump in drug use occurs when students go from their elementary or grade school to junior high or high school. There is one exception to the increase with age and this happens among the seniors. It appears that there are slightly fewer seniors in the more serious groups. One explanation for this is related to the high drop out rate at these schools. It might be that many of the students using drugs more heavily are the ones most likely to drop out of school. As a result they are not included in the survey.

School Adjustment

School adjustment was measured in two ways. Students were asked how well they liked school and how well they were actually doing in school. Both of these questions were related to the patterns of drug and alcohol use. Students using more drugs and alcohol reported higher levels of dissatisfaction with school and said they were getting lower grades than their classmates. Those students using fewer drugs or no drugs at all appear to be getting along best in school.

At this point it is difficult to answer the question "Does drug use lead to problems at school, or do school problems lead to drug use?" Actually, both are probably going on at the same time. Those young students who are doing poorly in school or who dislike school are more likely to get involved with drugs and, once they are involved with drugs, they may lose motivation and be less able to pay attention to their studies. If students who were beginning to lose interest could be identified early, maybe something could be done to keep them from turning to drugs. Right now, however, the important thing might be that the heavier durg users are putting distance between themselves from what could be an important source of help.

An important question might be "How can the schools re-establish contact with these young people and provide help for them?" This may be difficult since alienation from school is often accompanied by a strong reluctance to accept help. Young people with school adjustment problems are hard for teachers to influence, they are not likely to care whether teachers or even other students think that they are good persons. They are also not likely to believe what teachers tell them, particularly about drugs.

For some of these students, the family is also part of the school problem. Occasionally, the family's attitude toward school is negative and the student is picking up this attitude from home. For other students, pressures from the family to do well in school, when the student does not think it is possible, is the problem. Sometimes rebellion against parents' control turns into rebellion against the school. It is the student, the family and the school that are involved here, not just the school.

School adjustment does not seem to be a serious problem for students in the lighter drug use groups. However, we do konw that some students progress through these groups to heavier use so an "early detection" system for finding them when they are young might be worthwhile. Dealing with early signs of poor adjustment to school may head off later drug and alcohol problems.

Peer Influence

The results from the Pine Ridge survey indicate that peer influence is the most important factor related to drug and alcohol use. There are two separate ways that a child's peers influence drug use. Friends can encourage drug use by using drugs themselves and by asking others to use drugs. Friends can also work against drug use by applying pressure to stop a person from using drugs. While these two influences seem to be just opposite sides of the same thing -- if you had one you would not have the other -- actually both of them operate at the same time. A young person can have one group of friends that encourage drug use, and another group of friends that would try to stop it.

The general pattern of peer influence is very clear -- the high drug use groups have very high encouragement for nearly all drugs and there is very little effort to prevent others from use. The opposite is true at the other end of the scale -- for the Drug Experimentation, Light Alcohol and Negligible Use groups there is low encouragement from peers and quite a bit of effort to prevent friends from using drugs.

There are other patterns of peer influence that are quite interesting. For groups where one drug is used most often, encouragement to use and acceptance of use is high for that drug, but not for other drugs. Members of group 4, for example, those who use marijuana heavily but do not use other drugs, show a high level of encouragement and acceptance for marijuana, but not for other drugs. The same pattern is true for those who use primarily alcohol and so on. For the multiple drug use groups (groups 1, 2, and 3) encouragement and acceptance apply to several drugs, but even in these groups there is quite a bit of peer pressure against using heroin or PCP, and a lower use of these two drugs.

These patterns go a long way toward explaining how drug subtypes are formed. Some students may have friends using certain drugs. Because they are friends, there is a very strong pressure to conform, which means using those drugs. Other students who are already using certain drugs tend to select friends who are also using those drugs. Whatever the process of group formation, once the group is formed, it is highly self-reinforcing. Young people within that group encourage one another and do very little to stop each other from using those drugs that the group accepts. This self-perpetuating pattern becomes even stronger when there are other attitudes shared by the students, dislike to school for example. In the extreme case, such as the top drug use groups, a type of "subculture" develops which is highly resistant to change.

Family

Almost all Indian young people, no matter what pattern of drug use they have, feel that their families would not like to have them use drugs. Nearly all of the students said their families would care "some" or "a lot" if they were using any drug. But there is a tendency for more of the young people in the higher use groups (groups 1, 2, and 3) to feel only "some" pressure from their families not to use drugs, while most children in the low drug use groups feel "a lot" of family pressure against drugs. The slightly lower level of family pressure to stay away from drugs may make it easier for some young people to get involved with drugs.

A more important question, however, might be why the strong parental pressure against drugs that most young people feel does not have more influence on their behavior. Nearly everyone feels "a lot" of family resistance to drugs, but many children use drugs anyway.

Is this a normal adolescent stage where young people are moving away from family influence? Is peer pressure so strong that parental pressure makes little difference? Could it be that parents are not communicating these values often enough or strongly enough? It would seem that efforts to prevent dangerous use of drugs might focus on ways of increasing the actual effect family attitudes and beliefs have on the behavior of young family members.

The question is occasionally raised as to whether or not young people from single parent homes have more serious drug problems. The survey data indicate that there is a slightly higher percentage of students from homes where either the father or mother is absent in both the Polydrug and in the Heavy Alcohol groups. This by no means implies that all young people from single parent homes will use drugs or alcohol dangerously. In fact, many of them are in the low or non-use groups.

Attitudes Toward Drugs

Here again we have a lot of variability in how the different groups view the dangers of drugs. As might be expected, those students using more drugs and using them heavily see fewer dangers associated with them. On the other hand all classes of drugs are seen as at least a little dangerous. Very few, if any, Indian students believe that drugs and alcohol are danger free. The differences among groups are usually on the basis of how much of a drug is used. Students in the heavier use groups respond that "a lot" is harmful, while those using few or no drugs report that even "a little" is harmful.

Students see less danger in the use of the particular drug that they use most. For example, students in group 4 who use marijuana heavily but do not use other drugs, see less harm in using marijuana than most other groups, but they see more danger from other drugs than in any of the other seven groups. In part, this is self-deception. People don't like to admit that what they are doing is really bad for them. But there is also some acceptance of danger. Those using drugs do often feel that using "a lot" of a drug will hurt them. They use the drug anyway. But they tend not to use those drugs where they feel that even using a little is harmful, drugs such as PCP and heroin.

At the other extreme, the students who believed that none of these things were more than "some" wrong were likely to use drugs. If they also admitted to doing all of these things at least sometimes, they were likely to be in one of the heavier drug use groups. So the young people who were the most deviant in terms of general social norms were also likely to be the most deviant in terms of accepting and using drugs.

Most students, of course, fall somewhere in the middle. They believe that these things are wrong, but mark an occasional item (usually lying) showing that they feel it is not very wrong. They also rarely engage in any deviant behavior. They do admit to doing one or two of these things, but "not much". Many of these young people also use drugs, mostly alcohol or marijuana, but few of them are in the serious drug use groups. They seem to be saying on the survey, "Usually I agree with social norms -- but occasionally I do something that is a little wrong. I also occasionally use alcohol and marijuana, something that I also feel is a 'little wrong'." They do not feel that in either case they are doing anything that is really bad or really very much against social norms.

Summary of Factors Associated with Drug Use

The above discussion should make it clear that each area discussed changes as we move across drug use types. For instance, school adjustment is poor for most Polydrug Users; as we move through the groups, however, school adjustment improves until it becomes the most positive factor for those students in the Negligible Use group. Most of the other factors operate in much the same way.

In general, each of the areas discussed is a "risk factor" for harmful drug use. A student showing more of those risk factors is more likely to be using

There are also a few students who will use a drug that they know is dangerous or will use alcohol in very dangerous ways. Some of this use is to gain attention, to show off or to prove something to their friends. Some very disturbed young people are also using drugs in this way in order to get someone to pay attention to the serious emotional problems that they are having. It is like some suicide attempts, a plea for help. Those few students will make the plea obvious, showing their dangerous drug use to people who might help -- to teachers, counselors, good friends who will try to stop them, or their parents.

Deviant Attitudes and Behaviors

Most people believe that it is wrong to lie, cheat and steal. But some young people act out against social norms; they engage in antisocial acts of different kinds. They steal, vandalize, and do other things that adults generally feel are wrong. Do these students also violate the social norms that say using drugs is wrong?

We asked, on the survey, how wrong it was to lie, cheat in school, and steal. Nearly all students checked that it was either "some" or "a lot" wrong to do these things. But knowing that something is wrong does not always prevent people from doing it. When asked whether they do these things, a few said "never" to all the questions, but most young people admitted that they occasionally do some of these things.

The most conservative students marked all of the items as being "a lot" wrong, and also said that they never did any of them. Those young people, as might be expected, also were very unlikely to use drugs at all. They believe strongly in social norms, and would not violate them.

drugs. Remember however, that this is not a "black or white" situation. A few students with some or even many risk factors may not be using drugs at all. To use a simple example, poor school adjustment for a particular child may be related only to a need for glasses and may have nothing to do with drug involvement. On the other side of the coin, some young people with none or few of the risk factors may be using drugs and alcohol in dangerous ways.

All of this is to say that we are dealing with a very complicated problem and we cannot account for all of the individual differences. However, the information from the survey is consistent and is relevant for the majority of the students. It can be used to provide a basis for the development of programs to help reduce serious drug and alcohol use.

APPENDIX A

DESCRIPTION OF ADOLESCENT DRUG USE PATTERNS

Polydrug Use

For our purposes, we will define polydrug use as regular and continuing use of two or more different kinds of drugs. Nearly all in this group use alcohol and marijuana heavily. In addition, most use some kind of uppers, and occasionally take downers or hallucinogens. Polydrug Users are part of a drug subculture, and are experimenting, often heavily, with a wide range of drugs. They are not taking drugs just because one drug makes them feel particularly good. This is shown by the fact that they take drugs that have markedly different actions. There is some feeling that they will take nearly anything they can lay their hands on.

While their drug use is the highest of all student groups, it is important to keep their use in perspective -- they are not necessarily in a continually drugged state. Except for marijuana, most use is mostly confined to weekends, and only occasionally during the week. Most of these students function quite well on a day to day basis as evidenced by the fact that they are in school. On the other hand, it is quite probable that many polydrug users have already dropped out of school, possibly for drug-related reasons.

Several variations of Polydrug Use exist. The first consists of students who use a wide variety of drugs (four to seven different ones), have used several of them recently and use them in particularly dangerous ways (e.g. injecting cocaine with a needle). Marijuana is used daily and most in this group have been drunk recently.

A second variation is similar to the previous one but the overall level and intensity of use is less. There is still a marked pattern of using uppers and downers.

A final Polydrug group prefer daily use of marijuana and frequent use of downers. In addition they are willing to occasionally use other drugs such as PCP or LSD along with moderate drinking.

Stimulant Use

The next major category of drug users are marked by their preference for stimulants and their rare use of downers. These people are similar to Polydrug Users in that they use a variety of different drugs, but they are showing more selection -- seeking more specific responses from the drugs that they use. Being drugged is not enough. They appear to want to feel active and alert while using drugs, thus they use those drugs with a reputation for making you feel excited and "up"; alcohol, marijuana, amphetamines, cocaine, and to some extent, hallucinogens. The fact that alcohol is a physiological depressant is not as important as its social use in relation to parties and its reputation for loosening inhibitions and making you feel good.

There are three subgroups of Stimulant Users that differ somewhat in amount and type of drug use. The first group prefers amphetamines and hallucinogens, although cocaine use is also quite common. These students prefer an intense drug experience so even when they use marijuana and alcohol it is liekely to be in large amounts.

A second Stimulant group shows a preference for marijuana and cocaine although amphetamines will be used when cocaine is not available. This group resembles the previous one but the intensity and frequency of being high are less pronounced.

The last Stimulant variation involves marijuana, alcohol, and occasional but continuing use of amphetamines. As with most of the Stimulant Users, downers may have been tried but not continued.

Periodic Drug Use

Nearly all of this group use some marijuana, and may use it quite often. In addition, all are using some other drug, often a hallucinogen or inhalants. They have not only tried another drug, but are still using it occasionally, generally at least once during the last two months. While drug use is not very heavy, they have shown a willingness to be involved with a drug and may increase that involvement over time. As with most of the drug use groups we are describing, there seems to be a set of attitudes here which are as important as the actual drug use. Periodic Drug users probably do not feel that drugs are all that bad and if conditions change slightly (e.g. increased drug availability or higher stress) they could easily move toward a higher drug use group.

Marijuana and Alcohol Users

All students in this group use marijuana and nearly all use alcohol as well. Other drugs are not used to any significant extent. Alcohol and marijuana are now the drugs associated with social activities among young people. Alcohol use is tolerated and even legal once the child reaches the appropriate age, but marijuana use is now so common that it appears as a social drug as well. It is illegal and not usually approved by adults, but it is a definite part of the adolescent social scene.

There are three subgroups of Marijuana Users. The first subgroup uses it quite heavily and uses it during the week. About half are moderate to heavy drinkers who may drink quite a bit most every weekend.

A second subgroup use marijuana mostly on weekends or holidays and it appears to be in more of a social pattern. Alcohol use is as heavy or perhaps even heavier than in the previous group -- some drinking is occurring during the week and drunkenness is common, even to the point of passing out.

The third variation in this group use alcohol and marijuana about equally but most use is confined to weekends. They are rarely drunk and rate themselves as light marijuana users.

Drug Experimentation

None of the students in this group are using any drugs on a continuing basis, but they have been willing to at least try a drug. As might be expected, the most likely drug to try is marijuana, and all but a few have tried marijuana. Next most likely are amphetamines. A few have tried some drug, a hallucinogen, PCP, or a downer. Nearly all have at least tried alcohol, and most use alcohol a little, some enough to get drunk. The two patterns found within this group are experimentation with marijuana plus another drug and experimentation with marijuana plus a little alcohol use.

Light Alcohol

In this very small group alcohol is used occasionally and generally on weekends. Some in the group have used enough to get drunk once in awhile but most of them do not. No other drugs have been tried.

Negligible Use

In this group there is no real use of alcohol or of any drug. Some of the people have tried alcohol but it is not being used now even socially. No drug has ever been used.

A Special Note on Alcohol and Inhalants

There is good evidence that alcohol and inhalants are very widely used by the students surveyed. In the patterns described above however inhalants do not mark any of the major groups and those groups labeled "alcohol" are not at the top of the list. From this it would seem that perhaps alcohol and inhalants are not that serious of a problem. Actually, alcohol and inhalants are used quite a bit by students in the more serious groups -- the groups themselves however are marked by other more obvious patterns. For instance, "Polydrug Use" seems to be a good label for those using a variety of both uppers and downers. Students in this group are, however, also using a lot of alcohol and inhalants. The same is true for "Stimulant Users" and "Periodic Drug Users". What has been found is that the more serious the drug use, the more serious also is the alcohol and inhalant use.

APPENDIX B

CHILDREN'S DRUG USE TYPES

1. Child Polydrug

These children are using both inhalants and marijuana on a continuing basis. They are not just experimenting, they are using some kind of drug almost every week. The drug may be an inhalant. If so, they are likely to take enough of it so that they either feel it a lot or almost pass out. It may be marijuana, usually taken with friends. It may be alcohol, drinking it with friends and occasionally enough of it to get drunk. At one time or another they will use any of these three drugs. Quite a few have also tried some kind of "pill", usually an upper, but they only do this rarely.

While polydrug use in adolescents involves uppers and downers and these younger children are not using those drugs, the term "child polydrug" is still appropriate for them. They are not just using a single drug, they are willing to take different kinds of drugs and are already joining together into a drug subculture. They are very likely to move on to other drugs as those become more available in junior high and high school.

2. High Drug Involvement

These children are not using both marijuana and inhalants, but they are using one of these drugs quite often. If the drug is marijuana, they are likely to be using it once a week or more. They sometimes use it during the week, not just on weekends. If they are using inhalants, they are using them at least once a month, and quite a few of them take enough drug so that they feel it a lot or nearly pass out. They are less likely to have been drunk than the children in the child polydrug pattern, but quite a few have been drunk, and most will use alcohol when they can get it.

These children are not using drugs heavily. They use them only occasionally, but they are not just experimenting once in awhile, they are using the drugs regularly. It would be rare for a month to go by without them using a drug. So they are drug involved, and that involvement is likely to increase over time.

3. Light Marijuana Use

These children use marijuana occasionally, probably once every two or three months. They are not drug users, but have shown that they are willing to take a drug and that they will be willing to do it again. Those who use alcohol use a little bit with friends. They do not get drunk very often. They are likely to continue using drugs and will probably increase the frequency that they do so. Some will increase use and go on to other drugs. Others may just use alcohol and marijuana socially. Unless something happens in the community, though, they are very unlikely to reduce their drug use. They are showing drug involvement at a very early age.

4. Alcohol

These children do not use any drug but alcohol. They use alcohol at most once or twice a month, and usually use it only a few times a year. There are two subgroups -- in one group the children have used enough to get drunk, in the other they have not been drunk, but have used alcohol with friends. Both groups have done more than just taste it or try it out at home. They are, as very young children, already using alcohol as a social drug, and some have used enough to get drunk. Alcohol use is likely to continue and grow more frequent, and most of these children will also begin to use marijuana during the next few years. Some will go on from there to further drug use.

5. Drug Experimentation

These children have tried marijuana or inhalants, but are not continuing to use either one. Their only danger is that they have shown a willingness to experiment, that they have been in touch with drug sources and with other children who are willing to teach them how to use drugs. They are, therefore, at risk -- they're in a position to increase drug use.

6. Negligible Drug Use

Some of these children have tried alcohol, but they have only used alcohol to taste it or used it in a small amount with their family at home. Most of them have never tried any drug at all, including alcohol.

ALCOHOL AND DRUG ABUSE
ON THE
PINE RIDGE INDIAN RESERVATION

SUMMARY REPORT

BACKGROUND:

This is a summary report of alcohol and drug abuse on the Pine Ridge Indian Reservation. This is the home of 18,000 Oglala Sioux Tribal members, the largest Sioux reservation and second largest Indian reservation in the United States. The land base covers approximately 2,786,540 acres. The reservation is 90 miles long from east to west and 48 to 56 miles wide from north to south. Given the large territory the population is scattered throughout the reservation to over 89 communities which range in populations from 50 to as large as 3,764. Twenty seven of the 89 communities have a population of more than 100 people. Pine Ridge is politically subdivided into 9 political districts: Pass Creek, Medicine Root, Wakpamni, Porcupine, White Clay, Pine Ridge, Wounded Knee, LaCreek, and Eagle Nest. Each political district elects representatives to the Oglala Sioux Tribal Council wherein each representative represents 500 people per councilperson with a remainder of 250 people per councilperson. A district of 750 people could technically have two representatives.

The Oglala Sioux Tribe and Indian Health Service Unit have the responsibility of providing health service to the large territory and scattered population from sparse remote areas to more population intense areas such as Kyle and Pine Ridge villages.

The Oglala Sioux Tribe through the Oglala Sioux Tribal Health Authority, a chartered organization representative of the 9 political districts and reservation wide in responsibility and authority has declared alcohol and drug abuse among our people to be the single worst problem and number one health problem of the Oglala Sioux Tribe.

INTRODUCTION:

Early American history slightly mentions the plight of the American Indians by simply stating the "red man is brushed aside by economic need." Only the American Indian can relate the brutal effects of the dehumanization process of genocide and imposed assimilation policies of the United States government towards Indians. The land grabs, starvation, military campaigns, government schools, and missionizing attempts and lately the well intentioned do-gooders and political activists all prove one point "never let the American Indian think, speak, live or act for themselves." This paternalistic policy has existed and has only recently diminished somewhat with the passage of the "Indian Self-Determination And Education Act of 1970." The congressional act allowed Indian tribes to contract federal programs and dollars, administer, staff, and operate these programs under their own direction and benefit. This has helped overcome the long imposed attitude of helplessness and inability to overcome one's own problems. It has also allowed Indian tribes the ability to set their own goals and objectives and methods to accomplish their program goals. The Pine Ridge Indian Reservation through the Oglala Sioux Tribal Council, the Oglala Sioux Health Authority, District and Community Councils, traditional and contemporary leadership and mainly through those concerned tribal members working for sobriety have taken advantage of federal contracting to combat alcohol and drug abuse. There are two Oglala Sioux Tribal programs that have contracted federal monies to alleviate the alcohol and drug abuse problem and they are; 1. Project Phoenix and 2. Project Recovery. There are other agencies that provide services for chemically dependent individuals and/or their family members by virtue of their position and/or agency. These include educators, school counselors, mental health counselors, law enforcement, clergy, traditional healers and leadership, judges, prosecutors, and Bureau of Indian Affairs social services.

Alcohol and drug abuse is the single worst problem affecting the entire Oglala Sioux people. It is considered the number one health and social problem facing our people today. In considering the devastating effects upon family, health, society, and the very fabric of the Oglala Sioux culture and way of life, we must understand the problem(s) did not suddenly appear among our people, but took generation upon generation of continual abuse before taking its cumulative effect.

The issue of alcohol and drug abuse or chemical dependency becomes increasingly complex, mainly because one problem leads to another at a variety of levels. People who abuse alcohol or chemicals, as well as being victims themselves, have an adverse impact on those with whom they associate. Employers, friends, relatives, and most of all families of alcoholics suffer from the effects of alcoholism. Many man hours of work are lost because of absenteeism and inefficiency due to alcoholism. Relatives and friends are manipulated into making excuses and covering up for the alcoholic. The promises of reform, although short-lived are believed because those who want to believe them and, as a result, they unknowingly become part of the disease pattern.

Those who are the closest to the alcoholic or chemically dependent individual suffer the most. Each family member is required to take more responsibility, including the children, to cover-up for the alcoholic or chemical abuser. There is little question that there are large numbers of children leading abnormal lives in alcoholic homes. These children learn at a very early age that alcohol(ism) or chemical dependency is an approved behavior and therefore grow up to teach their children the same behavior characteristics. On the Pine Ridge Indian Reservation it has been estimated that approximately 30% of the population suffer from chronic alcoholism. This has been estimated by the numbers of outpatient visits and incarcerations for the 1983-1984 year. It has also been estimated that 99% of the entire population is adversely affected by alcoholism. This has been determined becuase of the fact that within each family unit there is an alcoholic or chemical abuser, and if this is not so within the immediate family then it is true within the extended family unit.

What the end product has become for the Oglala Sioux Tribe is an entire society affected or afflicted by alcohol abuse or chemical dependency that immediate action is necessary to counteract any of the devastating effects alcoholism and chemical dependency has had on our people. Hope for the future generation(s) through education and prevention is a necessary must for the very survival of the Oglala Sioux Tribe.

ARREST STATISTICS:

The Oglala Sioux Tribal Juvenile Court has reported that there were 603 arrests of juvenile offenders on the Pine Ridge Indian Reservation. These arrests were for Driving While Intoxicated, truancy, runaways, fighting, curfew violations, sexual assault, and theft. The Oglala Sioux Tribal Chief Judge, Robert Fast Horse estimates that 47% of these crimes were alcohol related, either directly or indirectly. Directly by the fact that the juvenile offender was intoxicated or indirectly by the fact that the juvenile was committing a crime to obtain alcohol or other drugs.

The use of intoxicants by Oglala Sioux Tribal members is a problem in and of itself, however, the user often becomes an abuser leading to behavioral problems. This can be in the form of self inflicted abuse or abusive behavior toward others. Once the behaviorial problems become a criminal offense it becomes another statistic. On the Pine Ridge Indian Reservation the statistics relating to offenses that are related to alcohol or drug abuse are 99.5 percentile. This means, according to the Oglala SIoux Tribal Prosecutors and Judges, the criminal offender is almost always intoxicated while in the commission of a crime. The Oglala Sioux Tribal Law and Order Code has two offenses directly related to drunkeness or drug abuse, these sections are Section 74 D wherein a violation occurs when "a person appears in a public or private place in an intoxicated condition," and Section 1, part 1 of the Oglala Sioux Tribal Motor Vehicle Code which is "Driving While Under The Influence of Alcohol and Drugs." The following statistics are reservation-wide, listed by political district and number of arrests on a per annum basis. Included are also non-enforcement services or assistance to citizens statistics.

	PINE RIDGE	WAKPAMNI	PASS CREEK	WOUNDED KNEE	PORCUPINE	WHITE CLAY	EAGLE NEST	MEDICINE ROOT	LACREEK	TOTALS
ASSAULT	55	4	8	3	11	3	13	23	1	121
ASSAULT & BATTERY	186	13	13	22	25	30	13	26	0	328
BREAKING & ENTERING	36	6	6	11	8	12	12	26	2	119
CHILD ABUSE	7	1	1	3	5	3	3	6	1	30
CONTRIBUTING TO THE DELIQUENCY OF A MINOR	6	1	1	0	1	1	2	3	0	15
DISORDERLY CONDUCT	93	17	7	242	21	163	16	64	2	625
DRUNKENESS	1144	181	194	99	493	161	433	712	24	3441
INHALING TOXIC VAPORS	2	0	3	0	0	21	2	0	2	30
LIQUOR LAWS	15	5	7	12	5	4	20	26	0	94
MALICIOUS MISCHIEF	67	1	16	13	18	30	17	21	1	184
NARCOTIC LAWS	9	0	2	0	0	2	2	5	0	20
THEFT	171	11	14	36	25	68	28	54	1	408
VANDALISM	7	0	3	4	4	3	1	3	0	25
DWI	96	15	68	21	28	24	47	68	4	371
RECKLESS DRIVING	37	4	6	6	0	11	1	5	0	70
OTHER TRAFFIC VIOLATIONS	74	8	46	52	9	125	50	61	2	427
MAJOR OFFENSES	72	5	2	8	2	15	5	3	0	112
OTHER OFFENSES	427	58	88	76	136	203	139	264	4	1395
NON-ENFORCEMENT SERVICES	2635	510	958	1416	1659	2491	1010	2405	485	13569
TOTALS	5138	840	1443	2024	2450	3370	1814	3775	529	21383

FETAL ALCOHOL SYNDROME:

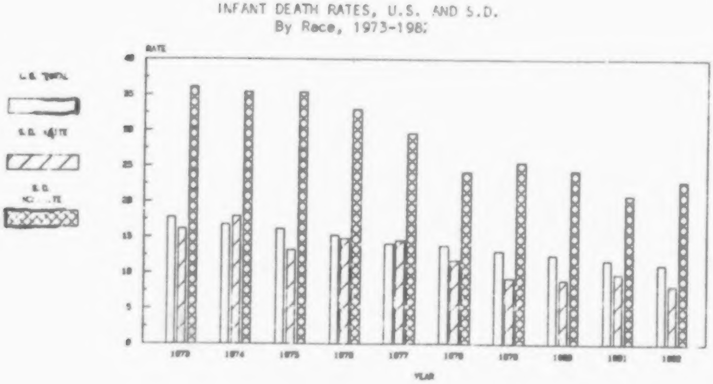
Although there are many references throughout history to the abnormal appearances and mental slowness of children born to women who drink alcohol it wasn't until 1973 when Dr. David Smith, a physician from Seattle, Washington diagnosed the specific pattern of malformations in his alcoholic patients and developed the term "Fetal Alcohol Syndrome".

Fetal Alcohol Syndrome refers to an array of symptoms occuring in the children of heavy drinking and alcoholic patients. There are four major clinical features of Fetal Alcohol Syndrome.

1. Central Nervous System dysfunction; including mild to moderate retardation, small head, poor coordination, irritability, and hyperactive behavior.
2. Growth deficiencies: below normal weight and length are usually present at birth and frequently persist during the postnatal period.
3. Atypical facial appearance: includes short palpebral features, (eye slits) myopic small eyes, droopy eyelids, a thin upper lip and midfacial and jaw growth deficiencies.
4. Various malformations: especially of the heart, kidney and skeltal organs.

A continum of fetal alcohol effects (FAE) can range from prenatal death and Fetal Alcohol Syndrome (FAS) to more subtle, yet still incapacitating neurological disorders with no physical abnormalities. The average I.Q. of children with FAS has been in the mildly retarded range (60 to 75).

Although Indian Health Service Units have only recently begin to record any presence of Fetal Alcohol Syndrome or Fetal Alcohol Effects in newborn babies these symptoms are not always present at birth. A lot of the symptoms remain "Hidden" until a child becomes of school age and then discovered through school diagnosis. Due to the fact that there is not an accurate data collection at the present time to determine the numbers of children afflicted by exposure to alcohol before birth, the infant mortality report furnished by the State of South Dakota Department of Health shows that the Indian Infant Mortality rate is sometimes double that for the white population. The infant mortality rate among Native American children in the State of South Dakota can often be directly linked to Fetal Alcohol Syndrome type of symptoms.


INFANT DEATH RATES, U.S. AND S.D.
By Race, 1973-1982

HEALTH STATISTICS:

The Indian Health Service, in the Department of Health and Human Services, provides free health services at the Pine Ridge Service Unit to both reservation and some off reservation Indian people. "Our Brother's Keeper: The Indian in White America 56-58 (E. Cahn ed. 1969) excerpts concerning:

> "the life expectancy of Indians on the reservation is nearly one-third shorter than the national average."

The Pine Ridge - Indian Health Service Unit, Aberdeen Area statistics give some indication why this is a continuing fact. The following are facts and totals of "deaths by age [illegible]" and "injuries". Given the correlative law enforcement data concerning alcohol or drug related offenses it is obvious and staticsally evident that a very high rate of deaths and injuries are also alcohol and drug related.

(SEE ATTACHMENT B)

NEEDS ASSESSMENT:

The existing chemical dependency programs on the reservation, which are Project Phoenix and Project Recovery cannot deal effectively with a problem as wide-spread as that which exists on the Pine Ridge Indian Reservation. This is not intended as a criticism of the services being provided, but used only to point out the gaps that exist in the reservations service delivery system. The "Continum of Care" is an essential part of a community's comprehensive plan i.e. prevention and referral program, social or medical detoxification unit, long term treatment program, halfway house, follow up and support groups, and family programs designed to deal with the alcohol abuser or chemically dependent individual and his/her family members.

In order to provide an adequate service system to rehabilitate clients and their families the Pine Ridge Indian Reservation is in need of the following:

1. Adequate funding to provide for [illegible] ment facility that would work with I[illegible] cal free facility on a long term ba[illegible] eir families.
2. Adequate funding to provide a medical [illegible] t for clients. This facility would provid[illegible] a 24 hour basis and would work in conjunctio[illegible] ublic Safety Commission.
3. Adequate funding to hire trained and professional staff to provide quality services for clients and their families.
4. Adequate funding to provide a comprehensive prevention program that would education the general public about alcohol abuse. This would include medical aspects of alcoholism, fetal alcohol syndrome, and the family concept of alcohol abuse.

CONCLUSION:

The disease of alcoholism is four-fold in its effect on the human personality. It is emotionally, psychologically, physically and spiritually erosive. Therefore it cannot be successfully treated by any one isolated discipline be it psychiatry, psychology, medicine or religion. A multi-disciplinary approach that treats neither the symptoms nor the consequences of alcoholic addiction, but rather the disease itself. In dealing with such a complex issue of alcohol abuse it is important to remember that "an ounce of prevention is worth a pound of cure", is very applicable in this case. Teaching our children the consequences of alcohol or chemical dependency before they become a reality in their lives is necessary to ensure the survival of the Oglala Sioux Tribe.

In short the needs exist to provide meaningful effective and continuing prevention and treatment for alcoholism and chemical dependency among the Oglala Sioux Tribal members with special attention upon our youth. The concern needs to be supported by public awareness, public officials, alcohol and drug abuse programs and adequate and continuing alleviation of this drastic disease.

There is need in the "Continum of Care" analysis for detoxification and treatment facilities for juvenile offenders. There are needs for:

1) Cooperation among the Bureau of Indian Affairs and Indian Health Service in providing services and pertinent data available to the Oglala Sioux Tribe.
2) Prevention and outreach programs on an expanded scale to individuals, families, communities, schools, groups, throughout the reservation.
3) Training for tribal, state, and federal personnel including

law enforcement, counselors, health care personnel specifically on the alleviation, recognition and treatment of of alcohol and drug abuse.

4. Education concerning the long-term effects of alcoholism or alcohol abuse on the unborn child; and

5. Continuing congressional support of existing alcohol and drug abuse programs and appropriations to create and expand these programs to more realistically approach this problem.

DRUG USE AMONG THE STUDENTS ON THE PINE RIDGE INDIAN RESERVATION 1980-1982

INTRODUCTION

Drug use by young people is a sensitive topic in most communities. Some people try to ignore it and say that very little drug use is going on. Other people become very alarmed and tend to exaggerate the level of drug use in order to give it attention. It is not often that accurate numbers are available so that the real size of the problem, and possible solutions, become clear. Fortunately, the schools on the Pine Ridge Reservation have chosen not to ignore the issue and have cooperated in a series of drug and alcohol use surveys. These schools have worked with Western Behavioral Studies at Colorado State University to administer a questionnaire to their students in the 4th through 12th grades. The first group of surveys were given in the schools in the fall of 1980. Based on those results a full report was written and delivered to all of the schools. In addition, each school received a report with the results just for their students.

The present report covers the results of a second round of surveys given in the same schools in the fall of 1982. Since these surveys are separated by a two-year period of time, it should be possible to see if any important changes in drug use have taken place on the Reservation.

The report contains two major sections. Section I is the largest and will be a full report for all of the Pine Ridge schools combined. In Section I there will be 1) background material which describes the survey, 2) a description of the recent adolescent results (grades 7-12) and a comparison with the 1980 results, 3) a comparison of the adolescent results with a national, non-Indian survey, and 4) a description of the results of the recent younger children's survey (grades 4-6) and a comparison with

1980 results. In addition, several appendices provide materials that will help in understanding drug use at Pine Ridge.

Section II is a report of the results for each individual school. Section II will be different for every school and each school will receive only its own results. The schools alone may decide who they will share their results with. No information will be disseminated from Western Behavioral Studies without explicit permission from the tribe and/or the school.*

Appreciation is expressed to Mr. Emanuel Moran, Agency Superintendant for Education at Pine Ridge South Dakota for his assistance in this project. We would also like to thank the principals, teachers and other cooperating staff at the following schools:

Oglala Community School
Crazy Horse
Batesland
Wolf Creek
Red Shirt
Rocky Ford
Porcupine
Loneman
Manderson
Allen
Red Cloud
Little Wound
Our Lady of Lourdes

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* Only Section I will be sent to those with a legitimate interest in general conditions at Pine Ridge. Again, Western Behavioral Studies will not disseminate these results further without tribal permission.

SECTION I

SURVEY RESULTS FOR ALL
PINE RIDGE SCHOOLS 1980-1982

PART I: BACKGROUND

Survey Description

The surveys were paper and pencil questionnaires that the students filled out during a school class period. Two forms of the survey were given. The form for the 4th through 6th graders had 128 questions and the form for the 7th through 12th graders had 166 questions. Most of the questions were multiple choice although some asked the students to write in short answers.

The surveys were completely anonymous and great care was taken to make sure that no individual student's answers could be identified.

The survey had questions that asked about drug use and about those things that might relate to drug use. The first few questions asked about background information (age, sex, etc.). These were followed by a large group of items which measured the use of alcohol, cigarettes, and nine other commonly used drugs (only alcohol, tobacco, marijuana, inhalants, and "pills" were asked about on the children's survey). Students were asked how often, how much, and when they used different drugs. After the drug use items came questions that asked about reasons for drug use, whether friends or family encouraged use or tried to stop use, and how harmful the students thought drugs were. The final questions asked about personal adjustment (depression, shyness, etc.), school adjustment (grades and liking for school), and how students felt about their future.

Description of Sample

The survey was usually given to all students in school on a particular day. In some cases this was not possible and for a variety of reasons some students were missed. Most of the time, however, this did not affect the results of the survey since those who missed do not represent a special group as far as drug use is concerned. For instance, if an entire class is away on a field trip this will not change the school drug use averages one way or another. The one important exception to this is the group of students who are absent when the survey is given. Some absentees are, of course, out of school due to illness or other unavoidable problems. A lot of the absentees however are students who regularly miss school and who may be showing other signs of deviance. Studies done with non-Indian high school students show higher rates of drug and alcohol use among the group of students who are absent from school a lot. The same is probably true for Indian students, so the actual drug use rates for all school students are probably a little higher than given in this report.

Another group of young people not included in this survey are those who have dropped out of school all together. This group probably has even higher rates of drug use than school absentees. Therefore, use rates for all Indian young people of school age may be quite a bit higher than those reported here.

Table 1 on the following page shows how the sample is broken down by certain characteristics. It is important to see the steady drop off in the percent of students in each higher grade. This very clearly shows the school dropout rate among these students.

Next, it is important to note that the 1980 and 1982 groups are very similar on the characteristics listed in Table 1. The 1982 sample contained slightly fewer students but the percent in each category seems to be about the same at that in the 1980 sample. Since the two samples are so similar in makeup, any differences that are found between 1980 and 1982 most likely reflect real changes in how drugs are being used. The one exception to the

Table 1

Student Characteristics for the 1980 and 1982 Surveys

	1980	1982
Number Surveyed		
4th-6th	712	660
7th-12th	1003	928
Sex		
Male:		
4th-6th	48.7%	51.2%
7th-12th	52.2%	52.1%
Female:		
4th-6th	51.3%	48.8%
7th-12th	47.8%	47.9%
Percent in Each Grade: Children's Survey		
Grade		
4	39.4%	31.4%
5	34.0%	33.5%
6	26.7%	35.1%
	Total = 100.0%	Total = 100.0%
Percent in Each Grade: Adolescent Survey		
7	23.1%	24.1%
8	21.2%	20.2%
9	18.6%	17.2%
10	14.5%	16.1%
11	12.9%	12.1%
12	9.7%	10.4%
	Total = 100.0%	Total = 100.0%
Race		
Indian	95.4%	98.3%
Non-Indian	4.6%	1.7%

similarity in samples is the percent of students in each grade for the 4th, 5th, and 6th grades. In the 1982 sample there appears to be more 6th graders. The effect of this will be discussed in the section on the children's survey.

Survey Accuracy

One of the first questions that should be asked about a survey is "How accurate is it?" Good surveys are not easy to build and even if that job is done well there are many things that can go wrong. It is important to have ways of telling if the survey is doing a good job -- if it is getting reliable information.

A number of things were done to check the accuracy of the surveys given at Pine Ridge. First, several questions were asked about the use of each drug. Sometimes students responded very inconsistently to these questions. For instance, in one place they may have marked that they had never tried a certain drug, but on another question they may have said they used that same drug on weekends and holidays. A little bit of inconsistency is allowable on a survey, sometimes a student just reads an item wrong, but if this kind of inconsistency happens too often on any survey, that survey is not used to calculate drug use rates. On the 1982 Pine Ridge survey less than 3% of the students answered the questions inconsistently.

Another way of checking for inaccuracies is to ask students about "fake drugs" -- drugs that really do not exist. On the 1982 Pine Ridge adolescent surveys less than 2.0% of the youngsters said they had used the fake drugs asked about on the survey. Some of these may have actually been trying to exaggerate their level of drug use. On the other hand, the names of the fake drugs could have been confused with real drugs the students had actually taken. Other students may have thought, "I've taken so many different drugs, I surely must have taken these". All in all it appears that very few students tried to exaggerate their drug use.

Finally, the last two items on the survey ask students how honest they had been in answering the questions about their drug and alcohol use. About 92% said they were "very honest". Of those who said they were not completely honest, almost half said they used more drugs than they said they did, and about half said they used less, so much of the error due to dishonesty would cancel out. There was, however, a slight underreporting of drug use by the adolescents but not enough to affect the overall rates significantly. For the younger children there was a tendency to underreport both drug and alcohol use. This may have been enough to slightly affect the use rates reported here and make them a little lower than they actually are for the 4th-6th graders.

All surveys contain some errors. The evidence given in this section shows that, while there were some minor inaccuracies in the way students reported their drug and alcohol use rates, the errors on this survey appear to be very small. A great deal of confidence can be placed in the results.

PART II: ADOLESCENT SURVEY

There are many ways of answering the question, "How serious is drug use in our schools?" In this section we will look at the problem several ways, but let's start with the simplest question, "How many students have ever used any amount of a given drug?"

Ever Used

On the survey students are asked "Have you ever used _______?" This question is repeated for alcohol, tobacco, and nine other drugs that are often used illegally. This is a very rough measure because it includes everything from one time use (even a sip or two of beer) to continued use at very dangerous levels. The question is still useful however. For one thing it will give some idea of how much exposure a youngster has to a variety of drugs. To use an extreme example, if 30% of the students in a school have tried cocaine -- even if most of them only used it once -- you can be pretty sure it is easily available and that there is a lot of pressure on every youngster to use cocaine. However, if only 1% have ever tried it, it would mean that the drug was not easily available and there is little peer pressure to use it. Another value of the "ever used" type of question is that it allows us to compare drug use rates in different parts of the country. There are many surveys given each year and most of them have the "ever used" questions. The Pine Ridge results will be compared with one of these other surveys later in this report.

Table 2 on the next page shows the percent of Pine Ridge students who have "ever used" the listed drugs -- the results are given for both the 1980 and 1982 surveys. Several important results are seen in the table. First,

Table 2

Lifetime Use of Drugs and Alcohol By All Pine Ridge 7th-12th Graders for 1980 and 1982

		1980		1982
Alcohol		80.7%		79.5%
Beer	78.8%		78.3%	
Wine	25.0%		22.4%	
Liquor	59.8%		56.4%	
Marijuana		73.1%		71.9%
Tobacco		63.9%		60.0%
Inhalants* (excluding cocaine)		27.1%		28.4%
Stimulants (speed, uppers)		20.6%		25.5%
Sedatives (downers, barbiturates or methaqualone)		8.5%		4.1%
Tranquilizers (Librium, Valium, etc.)		6.8%		3.7%
Heroin		3.9%		2.5%
Cocaine		11.1%		6.4%
PCP		6.7%		4.4%
Hallucinogens (LSD, mushrooms, etc.)		10.9%		6.1%

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* May be low due to known underreporting of Amyl and Butyl Nitrites.

in 1982 alcohol, marijuana, tobacco, inhalants and stimulants continued to lead the list of drugs this group has tried. There are slight decreases in alcohol, marijuana and tobacco since 1980 but not enough to be important. Likewise, the slight increase in inhalants is probably not important, but inhalants continue to be used very widely. The increase in stimulants is fairly large and, since this reflects a national trend toward more stimulant use, it is probably an important finding. The Pine Ridge adolescents seem to be following national trends.

Another important result is a drop in what might be considered the "harder" drugs. The use of sedatives, tranquilizers, heroin, cocaine, PCP, and hallucinogens are all down to some degree -- this is probably a significant trend. The reasons for the trend however can only be speculated on at this point. It could be that education and prevention programs are beginning to pay off and we are seeing the effects for these types of drugs. Another possible explanation might be that during harder economic times it is more difficult to obtain some drugs.

The most important result seen in Table 2 is that the overall level of exposure to drugs remains quite high among the Pine Ridge students and is still cause for great concern. The one encouraging note is that drug use is at least leveling off and in some cases may even be dropping slightly. This is the first time in several years that increases in drug use have not been found among Indian young people.

When the students were asked to list the inhalants they used, gas, glue and spray paint were most often mentioned. Listed psychedelics included LSD, "mushrooms", and mescaline. Showing the widespread use of marijuana, over 38% of all the students reported having used marijuana and alcohol together during the past year.

Recent Use

For several drugs information is available on the amount of recent use and the amount used each time. First we will look at use within the last two months as shown in Table 3.

Table 3

Percent of Pine Ridge Students Who Have Used
Drugs Within the Last Two Months for 1980 and 1982

	1980	1982
Alcohol	58.9%	60.3%
Marijuana	60.2%	54.5%
Inhalants	6.2%	6.1%
Stimulants	11.5%	9.1%

It appears that there is a very slight increase in recent alcohol use and a small decrease in recent marijuana and recent stimulant use. Recent use of inhalants is unchanged.

Daily use of marijuana has become an important indicator of drug misuse within the last few years. Because the chemicals in marijuana are gradually stored in the body, regular use can cause a serious buildup over time. In 1980 13.8% of the Pine Ridge students said they used marijuana daily. For 1982 this percent had dropped to 10.6%. This is an important finding and shows Pine Ridge is following the national trend of lower daily use of marijuana. Note, however, that this is still a large number of students to be using a drug daily.

Table 3 shows that nearly two-thirds of all Pine Ridge students used some alcohol in the past two months. How much did they use? One survey question asked how often they had been drunk in the last two months -- 24% had been drunk once or twice, 5% had been drunk three to nine times and 2% had been drunk ten or more times. These figures are nearly the same as they were two years ago so there is little sign that heavy drinking is tapering off much. Another question on the survey asked the students how many times they had ever been drunk enough to pass out. Twenty percent said this had happened once or twice and five percent said three or more times. This seems like very heavy drinking for 7th-12th grade young people.

Drug Use Patterns

The information given so far is helpful in understanding the general level of drug use among this group of students. For example, it is very clear that alcohol and marijuana are widespread, easy to get and routinely used by a large number of students. However, a lot of young people do not use only one or two drugs, some use several drugs and use them at the same time. Some students use drugs, or combinations quite often while others may do so only occasionally. A number of students may use only one drug, but use it regularly and in heavy amounts. What we will do next is to describe the many patterns of drug use that students commonly engage in. In the last section we talked about individual drugs and the percent of their use. We will now describe groups of students and the actual ways in which these students use drugs.

At Pine Ridge seven basic patterns of drug use were detected. The patterns were found by examining the answers to the drug use questions in order to find students who used the same drugs in about the same way. These are shown in Table 4. The groups are listed in order of the seriousness of their drug involvement.

Table 4

Percent of Pine Ridge Adolescents
in Each Drug Use Type

	1980	1982
1. Polydrug Users	8.0%	4.1%
2. Stimulant Users	9.1%	7.9%
3. Periodic Drug Users	6.4%	7.5%
4. Marijuana & Alcohol Users	36.0%	35.7%
5. Drug Experimenters	17.4%	20.5%
6. Light Alcohol Users	3.5%	4.0%
7. Negligible Users	18.3%	20.3%

At the top of the list are drug use groups who are the most heavily involved, next are those with lesser involvement until we finally end with a group who show little or no drug use. It is not always possible to place the groups in their exact order of seriousness. We sometimes have to use a judgment about which group may be in more serious trouble than others. Usually the total amount of drugs used is a good measure of the level of trouble someone may be in.

A complete description of each drug use type is given in Appendix A and the reader should look them over carefully before going any further.

In reading the descriptions of these groups try to think of ways in which these young people can be helped. After all, the major value this survey has is in finding ways to help those who may be having trouble because of the use of drugs. Young people in each of these patterns need different types of help. It is widely accepted, for instance, that education about the danger of drugs has little effect on students who are already heavily involved with several drugs -- they already know a lot about drug effects and tend to "tune out" when educational lectures or materials are presented. On the other hand, students who are starting to experiment with different drugs might benefit a great deal by knowing what the possible harmful effects are. Unless these kinds of differences in drug use types are recognized we are likely to make mistakes in our efforts to help young people.

Table 4 shows a fairly large drop in the most serious use pattern since 1980, a slight drop at the next level and a slight increase in the Periodic Drug Use group. Changes at the other levels do not seem important except that there are a few more Drug Experimenters.

The changes in patterns from 1980 to 1982 are similar to what was found in the earlier comparisons of "ever used" percentages. There we saw less use of many of the more "hard core" drugs -- the type that Polydrug Users might use. Therefore we may be seeing a shift away from the most harmful patterns of drug use. It is interesting to note that the Stimulant Users group has also declined a bit -- this in spite of the fact that Table 2 shows an increase in the number of young people who have tried stimulants. The description of the Stimulant Users group (Appendix A), however, shows that students in this group are using more than just stimulants, they are also using a hallucinogen, or using cocaine or using marijuana heavily. It appears that the increased use of stimulants is showing up in the lower drug use types such as Periodic Users or Drug Experimenters.

Keep in mind that, even though there has been a drop in the number of young people in the most serious drug use groups, there are still a large number of students who are at risk for serious trouble due to their level and pattern of drug use. These students are in immediate need of help by someone in their community. It is encouraging, however, to see that there may be a leveling off and perhaps the period of time when drug use was always getting worse has passed.

It would be helpful if we knew more about students in each of the patterns in Table 4 than just how they use drugs. How are they doing in school? How do they feel about themselves? What level of family support do they have? What are their friends like? How do they feel about their future? If we know the patterns of drug use and some of the other important personal and social problems faced by these students we could provide a great deal of help. Some of the things which have been found to be related to the drug use patterns are discussed in Appendix C.

PART III: COMPARISON WITH A NATIONAL SAMPLE

It is sometimes helpful to know how one location compares in drug use rates with the rest of the country. A comparison may give some idea of special problems in one place and it can also give a better idea as to the overall size of the drug problem.

It is always a little bit risky to compare two different surveys. There may be differences in the times they were given, the wording of the surveys, the way the surveys were given and so forth. No two surveys are exactly alike but if we are careful in our interpretation, it is possible to draw some helpful conclusions. It should be remembered that differences of just a few percentage points are probably not meaningful. Table 5 on the next page compares the Pine Ridge 12-17 year olds with a national sample of 12-17 year olds surveyed earlier in the same year.

The table shows the Pine Ridge students to have more exposure to alcohol, marijuana, tobacco and inhalants than the national sample. The rate of use of marijuana is especially high and again shows that marijuana use is very common among the Pine Ridge students. The high rate of stimulant use is also worth noting. Stimulant use has increased rapidly nationwide in the last two years and the same thing appears to be happening at Pine Ridge.

It is clear that all drugs used nationally are available at Pine Ridge and some drugs are used much more widely. It is encouraging to note however that Pine Ridge is showing similar use rates for some drugs such as tranquilizers and sedatives. This was not true two years ago when Pine Ridge was showing much higher use rates than national figures for nearly all drugs.

Table 5

Percentage of Students Having Ever Used Drugs -- 1982

	Pine Ridge Total (12-17 year olds)*	National Sample (12-17 year olds)**
Alcohol	79.3%	65.3%
Marijuana	71.4%	27.3%
Tobacco	59.4%	49.9%
Inhalants (excluding cocaine)	28.1%	9.8%***
Stimulants (speed, uppers)	24.6%	6.5%
Tranquilizers (Librium, Valium, etc.)	3.1%	4.8%
Sedatives (downers, barbiturates or quaaludes)	6.2%	6.1%
Cocaine	5.7%	6.9%
Hallucinogens (LSD, mushrooms, etc.)	5.3%	5.2%
PCP	3.5%	****
Heroin	1.7%	0.5%

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* These numbers will be slightly different than those found in Table 3 because they are for the 12-17 year olds only.

** This data is from the National Household Survey on Drug Abuse conducted by the George Washington University Social Research Group.

*** This is for a 1979 sample.

**** Not available.

PART IV: CHILDREN'S SURVEY

A simplified form of the drug survey was given to students in the 4th-6th grades. This survey asked only about alcohol, marijuana, tobacco, inhalants and "pills". The results of this survey will be reported in much the same way as they were for older students. First, the ever used and recent use percentages will be given and then a description of drug use types will be presented. National data on students this age are not available but we will be able to make comparisons with the survey data from Pine Ridge in 1980.

Ever Used

Table 6 shows the 1980 and 1982 percentages for lifetime and recent use of the listed drugs. Alcohol use has changed very little while the use of pills may have dropped slightly. Tobacco use appears to have increased moderately. The most important figures in Table 6 are the increases in inhalant and marijuana use -- this is shown both in the ever used and recent use categories. The importance of this will become clear as we next look at drug use patterns.

Table 6

Percent of 4th, 5th, and 6th Grade Pine Ridge
Students Using Drugs in 1980 and 1982

	Ever Used		Used in the Last 2 Months	
	1980	1982	1980	1982
Alcohol	23.3%	22.9%	15.5%	14.7%
Tobacco	23.2%	30.0%	--	--
Inhalants	12.1%	14.6%	7.0%	11.0%
Marijuana	17.1%	25.2%	3.2%	5.5%
Pills	8.7%	7.2%	--	--

Drug Use Patterns

Recall from the discussion of adolescent drug use that use rates for single drugs does not give the best description of how young people are using drugs. Of more interest are the patterns and combinations of drug use. Several common patterns of use have been found among the 4th-6th graders. The following table lists the six patterns found and the percent of students in each group. A complete description of these groups is given in Appendix B near the end of this report. These should be read before proceeding.

Table 7

The Percent of 4th-6th Grade Students in Each of the Drug Use Patterns for 1980 and 1982

	1980	1982
1. Child Polydrug	3.3%	8.0%
2. High Drug Involvement	5.7%	6.9%
3. Light Marijuana	6.1%	6.9%
4. Alcohol	4.7%	8.7%
5. Drug Experimentation	18.6%	11.4%
6. Negligible Use	60.2%	56.2%

Younger children, those in the 4th-6th grades, are not usually exposed to the whole range of drugs. Most of their drug use consists of alcohol, marijuana, and inhalants. The Child Polydrug pattern, therefore, does not include use of the heavier drugs. It consists of using both marijuana and inhalants on a regular basis (and usually alcohol as well).

. As seen in Table 7 the percent of young people in the Child Polydrug group has more than doubled since 1980. This is exactly the opposite of what has happened among older adolescents, where the heaviest drug use group has decreased. It is particularly important to understand what is happening here since it appears that drug use is leveling off, or even declining, among older students, but increasing among younger ones.

It is possible that, as these younger people grow older, we will, once again, see an increase in drug use. But that does not seem likely since the national trends and trends among Indian youth all show a leveling off that is likely to continue. It is more likely that what we are seeing among these younger children is the delayed effect of the great increases in marijuana use that have occured among older Indian children in recent years.

While use of marijuana and inhalants among older youth has finally leveled off, that has only happened recently. There is a general trend in drug use where drugs start with older youth, then younger children pick them up. It is this expansion downward that we are probably observing in the 4th-6th grade children. The recent large increases in marijuana use may have hit a peak among adolescents, but there is still plenty of room for it to expand downward -- thus we are seeing more younger children using marijuana now than were using it in 1980.

This is an important pattern. The younger children who are using marijuana and inhalants regularly are showing attitudes toward drugs that are dangerous. They are using those drugs that are available to younger children and have shown a willingness to get involved with more than one drug.

It is quite possible that what we are seeing is a trend toward a younger beginning age for the multiple drug use pattern -- both the Child Polydrug and the adolescent Polydrug User groups. So, while there may still be a leveling off of multiple drug use at the older ages, this pattern is slowly working its way downward -- very similar to what was seen for the single drug, marijuana. There is, of course, a natural lower limit to this downward expansion, probably around the 4th grade. Also, this "ripple effect" will probably run its course in two to three years, at which point polydrug use at the younger ages will also taper off. Naturally, this tapering off could happen much more quickly if effective intervention programs are put in place.

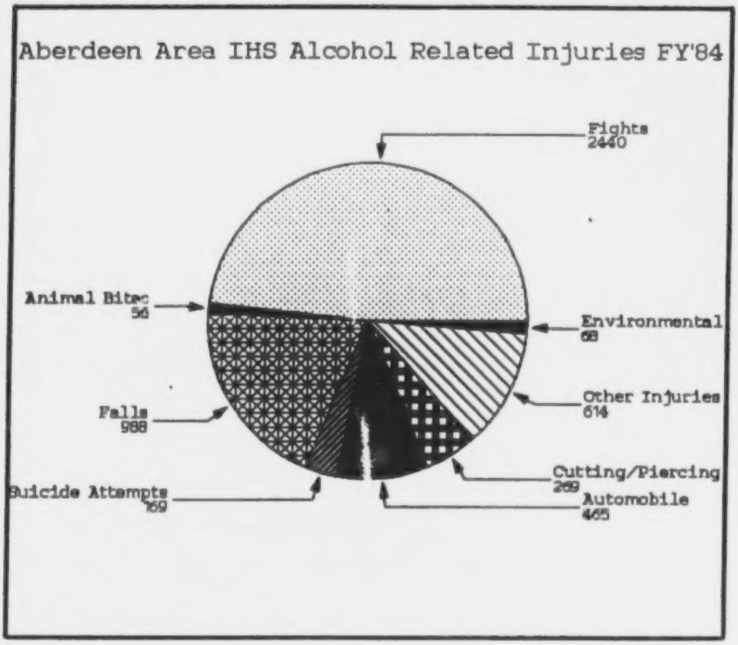
In Table 1 it was noted that the 1982 Pine Ridge children's sample was older than the 1980 sample. Since children use more drugs as they get older this could account for the increases described above. However, when the two samples were adjusted for age the same increase was found. The rise in use at these ages seems to be a very real thing.

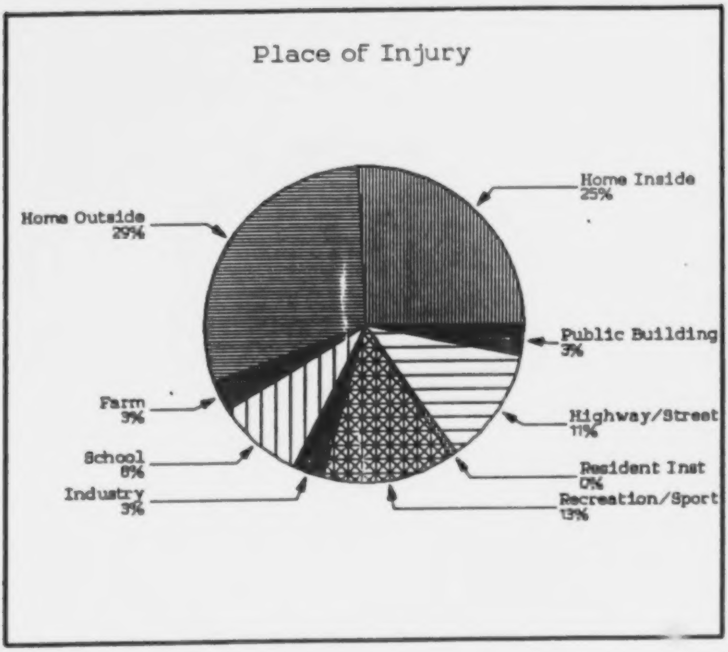
1982 - PINE RIDGE SERVICE UNIT
MOTOR VEHICLE-ACCIDENTS-SUICIDES-HOMICIDES
DEATHS BY AGE GROUP

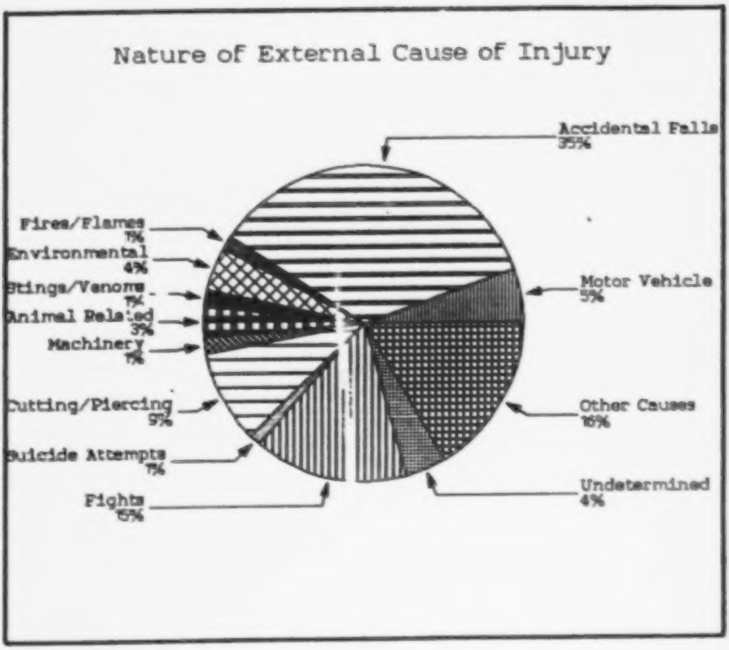
	Total	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65+
Motor Vehicle Accidents									
Collision w/another vehicle	1	0	0	1	0	0	0	0	0
Collision w/pedestrian	2	0	0	0	1	0	1	0	0
Collision w/vehicle/object	1	0	0	0	1	0	0	0	0
Not invol.Coll.on highway	5	0	0	2	2	1	0	0	0
MVA Unspec. nature	1	0	0	0	0	0	0	0	1
Subtotal	10	0	0	3	4	1	1	0	1
Accidents									
Misadvent med care/abnorm react	1	0	0	0	0	0	0	0	1
Acc. caused by fire/flames	1	0	0	0	0	0	1	0	0
Drowning & submersion	1	0	0	1	0	0	0	0	0
Late effect of acc. injury	6	1	0	1	1	0	2	0	1
Subtotal	9	1	0	2	1	0	3	0	2
Suicides									
By other/unspec. firearms	1	0	0	1	0	0	0	0	0
By other means/late effect of self-inflicted injury	1	0	0	1	0	0	0	0	0
Subtotal	2	0	0	2	0	0	0	0	0
Homicides									
Assault-other/unspec. firearms	2	0	0	1	1	0	0	0	0
Assualt-cutting/piercing instr.	2	0	0	1	1	0	0	0	0
Assault-other means/late effect of purposely inflicted injury by another person	3	0	0	1	0	2	0	0	0
Subtotal	7	0	0	3	2	2	0	0	0
Unspecified Injuries									
Injury undeter. if acc/purposely inflicted & late effects	1	0	0	0	0	0	0	0	1
Subtotal	1	0	0	0	0	0	0	0	1
Grand Total	29	1	0	10	7	3	4	0	4

1982 ABERDEEN AREA
DEATHS BY EXTERNAL CAUSE
(Source: Selected Vital Statistics for AAIHS 11/84)

	Aberdeen Area IHS	Cheyenne River	Fort Berthold	Fort Totten	Omaha - Winnebago	Pierre	Pine Ridge	Rapid City	Rosebud	Sisseton-Wahpeton	Standing Rock	Turtle Mountain	Yankton	Sac & Fox
MOTOR VEHICLE														
Collision w/another veh.	15		1	1	1		1		2	3	6			
Collision w/pedestrian	15		1	1			2	2	2	2	2	1	1	1
Collision w/object	2	1					1							
Non-highway collision	15		1			1	5	2	3	1	1	1		
Non-traffic accident	5	1		1				1	1			1		
POISONING														
Accidental drug poisoning	3		1						1		1			
Acc. poisoning other substance	1							1						
Misadvent. Medical care	2						1				1			
FALLS	3					1			1					1
FIRE & FLAMES	7	1		4			1		1					
DROWNING	11		1			1	1	2	4		2			
INHALATION SUFFOCATION														
Food/Object	2										1	1		
ACCIDENTAL FIREARM	2			1					1					
SUICIDE														
Hanging/Strangulation	4	1							2					1
Firearm	7	4		1			1			1				
HOMICIDE														
Assault-Firearm	6	1			1		2			1		1		
Assault-Piercing Object	2						2							
Assault-Other Means	9					1	3	1	2	1	1			
OTHER	27	3		3		5	9	1	3		1	1	1	
GRAND TOTA	138	12	5	12	2	9	29	10	23	9	16	6	2	3


Aberdeen Area IHS Alcohol Related Injuries FY'84
Fights 2440
Environmental 68
Other Injuries 614
Cutting/Piercing 269
Automobile 465
Suicide Attempts 169
Falls 988
Animal Bites 56


Place of Injury
Home Inside
25%
Home Outside
29%
Public Building
3%
Highway/Street
11%
Resident Inst
0%
Recreation/Sport
13%
Industry
3%
School
8%
Farm
3%


Nature of External Cause of Injury
Accidental Falls 35%
Motor Vehicle 5%
Other Causes 16%
Undetermined 4%
Fights 15%
Suicide Attempts 1%
Cutting/Piercing 9%
Machinery 1%
Animal Related 3%
Stings/Venoms 1%
Environmental 4%
Fires/Flames 1%

FY '84 Pop. 70,293

NATURE OF EXTERNAL CAUSE OF INJURY IN RELATION TO ALCOHOL

FOR THE Aberdeen Area SERVICE UNIT

(Figures taken from Ambulatory Patient Care Report)

INJURY	INJURIES FY '84	INCREASE (DECREASE) FROM FY '83	% ALCOHOL RELATED	INCIDENCE RATE/1,000 FY '84
1. Motor Vehicle Accident	1,314	25	36%	19
2. Water Transport	11	(5)	0	0
3. Air Transport	9	1	0	0
4. Accidental Poisoning	208	44	5	3
5. Accidental Falls	8,576	1,308	12	122
6. Fires/Flames	349	66	5	5
7. Environmental Factors	1,087	173	6	15
8. Stings/Venoms .	424	(8)	2	6
9. Animal Related	767	78	8	11
10. Drowning/Submersion	28	4	14	0
11. Cutting/Piercing Objects	2,247	209	12	32
12. Firearms Accidents	60	(7)	17	1
13. Machinery	409	34	6	6
14. Suicide Attempts	279	55	61	4
15. Injury Purposely Inflicted by Others	3,723	429	66	53
16. Battered Child	26	6	38	0
17. Undetermined Cause	1,157	227	12	16
18. Other Causes	4,128	259	9	59
TOTAL	24,663	2,898	21%	351
			FY'83	306

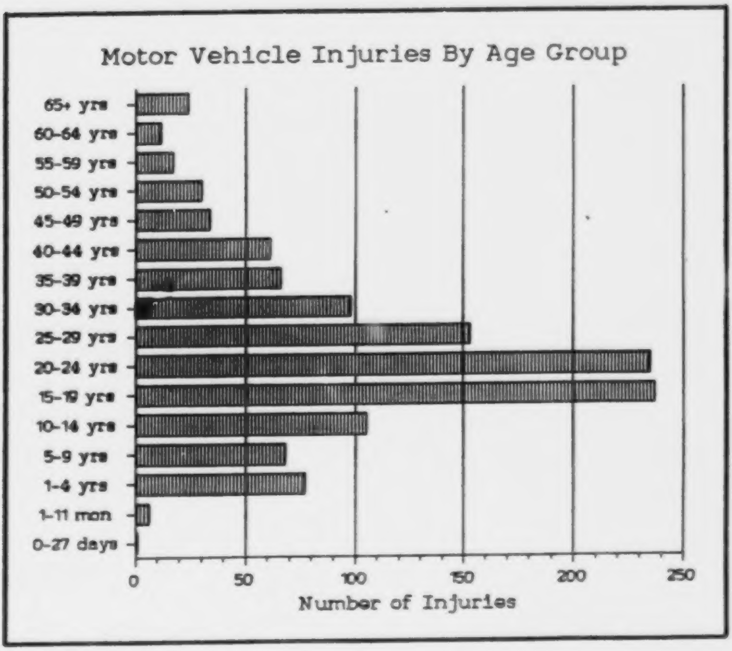
FY '84 Pop. 15,717

NATURE OF EXTERNAL CAUSE OF INJURY IN RELATION TO ALCOHOL

FOR THE Pine Ridge SERVICE UNIT

(Figures taken from Ambulatory Patient Care Report)

INJURY	INJURIES FY '84	INCREASE (DECREASE) FROM FY '83	% ALCOHOL RELATED	INCIDENCE RATE/1,000 FY '84
1. Motor Vehicle	298	112	38%	19
2. Water Transport	2	1	0	0
3. Air Transport	2	2	0	0
4. Accidental Poisoning	43	29	5	3
5. Accidental Falls	1,515	536	13	96
6. Fires/Flames	55	13	9	3
7. Environmental Factors	179	108	7	11
8. Stings/Venoms	59	1	0	4
9. Animal Related	149	36	9	9
10. Drowning/Submersion	5	1	20	0
11. Cutting/Piercing Objects	371	122	16	24
12. Firearms	14	5	21	1
13. Machinery	76	12	12	5
14. Suicide Attempts	61	48	56	4
15. Injury Purposely Inflicted by Others	633	199	73	40
16. Battered Child	3	1	100	0
17. Undetermined Cause	125	(4)	14	8
18. Other Causes	393	(23)	12	25
TOTAL	3,983	1,199	25%	253
			FY'83	182


Motor Vehicle Injuries By Age Group
65+ yrs
60-64 yrs
55-59 yrs
50-54 yrs
45-49 yrs
40-44 yrs
35-39 yrs
30-34 yrs
25-29 yrs
20-24 yrs
15-19 yrs
10-14 yrs
5-9 yrs
1-4 yrs
1-11 mon
0-27 days
0
50
100
150
200
250
Number of Injuries

APPENDIX II

FRIDAY, JUNE 14, 1985

ADDITIONAL MATERIAL SUBMITTED FOR THE HEARING RECORD

ALL INDIAN PUEBLO COUNCIL, INC.

TESTIMONY OF
GILBERT M. PENA, CHAIRMAN
BEFORE THE
COMMITTEE ON INTERIOR & INSULAR AFFAIRS
JUNE 14, 1985

Honorable Chairman and members of the Committee on Interior and Insular Affairs. My name is Gilbert M. Pena, I am Chairman of the All Indian Pueblo Council, comprised of the Pueblos of: Cochiti, Isleta, Jemez, Laguna, San Felipe, Sandia, Santa Ana, Santo Domingo, Zia, Zuni, Nambe, Picuris, Pojoaque, San Ildefonso, San Juan, Santa Clara, Taos, and Tesuque. With me is Joe L. Jojola, Project Director, of the "Two Worlds" Alcoholism Program. Thank you for giving us the opportunity to testify today on the HR-1156, the Juvenile Indian Alcohol and Drug Abuse Prevention Act.

A non-Indian once asked an Indian from one of the Pueblos what course of action would be taken if, for example, an old house located in the village was causing illness and death to those children who entered it, but could not be destroyed because of historical reasons. The Indian replied, "we would warn the parents and children about the illness and tell them not to enter the house or even play around it". He was then asked what the tribe would do if the children kept entering the old house out of curiousity or whatever reason they may have. The Indian again replied, "we could probably build a fence around it and place warning signs to keep the children out". Again he was asked what the tribe would do if the children ignored the fence and warnings from the parents. The Indian replied, "we would probably have to place a 24 hour guard around it to insure that the kids would not enter or play around the house". To that, the non-Indian asked, "alcoholism is an illness and is killing many of the young people who use it. Are your taking the same measures with alcoholism in preventing an illness or death, as you would have done with the old house"?

In reference to the anecdote I have just related to you, perhaps many of us have assumed that merely warning and lecturing our youth about the dangers of alcohol and drugs will deter them from experimentation and eventual use or abuse. We perceive that what we say or print, are sufficient means of prevention. The present rate of alcoholism, alcohol related morbidity, and alcohol related deaths among the Native Americans indicate that there is a need to expand on the present treatment modalities, including education and prevention. Until recently, we have spent much of our time and resources treating the chronic and en-stage alcoholics, including patients victimized by alcoholics, and have done little in terms of prevention and education. I sincerely believe that we are long overdue in developing effective preventive models that will produce measurable results.

The Bureau of Indian Affairs and the Indian Health Service have at their disposal, documents and data to support the fact that alcohol and drug use among the Indian begin at a very early age; perhaps as young as age ten (10). Reported incidences on juvenile delinquency, behavioral problems in schools and homes, and treatment of injuries, are directly related to substance abuse. A conjecture can be made, that the possibility of the young abusers becoming addictive to alcohol and drugs are extremely high, and that the problems manifest themselves in catastrophic consequences. In relation to this, the Census Bureau Report of 1980 relates that the median age for Native Americans in New Mexico is 20.2 years of age, while the mean age is at about 31 years. There appears to be a correlation between the percent of reported alcohol related criminal offenses committed by individuals within the median age group. The assumption is that the younger the population, the higher the percent of alcohol related offenses.

This information and testimony presented by others here today will undoubtly impress upon you the need to develop new and innovative methods of prevention and education specifically addressing the needs of Native American youth. I am pleased to know that this Bill, the Juvenile Indian Alcohol and Drug Abuse Prevention Act and its intended purposes, will provide us with the mechanisms and the resources needed to enhance the present efforts in education, prevention, and treatment of our youths. This Bill will also provide a positive direction for the Bureau of Indian Affairs, the Indian Health Service, and the Tribal Governments, to work collectively in minimizing and curtailing the problems of alcohol and substance abuse. Perhaps now, we can figuratively build fences and place 24 hour guards in the protection of our young people.

I would like to take this opportunity at this time to address some issues and make recommendations regarding this Bill:

It is without question that the overall intent of this Bill is both timely and worthwhile and, accordingly, is strongly supported. However, some issues need to be resolved and some of the recommendations here offered, should be closely considered by legislators.

a. No concise methodology has, to our knowledge, been formulated regarding the identification and screening of those Indian juveniles that might be potential offenders, and that would need the services outlined in the different titles of this Bill. Accordingly, the development of such identification criteria must be first formulated; preferably by existing service providers familiar with the extend and pervasiveness of the problem.

b. The need to accurately document the number of individuals needing such services, is self-explanatory in maximizing the impact of available funds.

Accordingly, data should be compiled that could outline the number, the locations to be impacted, and the severity of the problem with specificity.

c) Documentation on the successes and problem areas that exists within current programs that address this issue, should also be solicited. Accordingly, a network should be established of existing service providers, and the effectiveness of their current methodologies shared with others for possible duplication when applicable.

d) The cooperation, through direct involvement, of Tribal governances should be elicited. No other entity but a Tribe's own leadership is as well aware of the devastation caused by drug and alcohol abuse among its constituency.

Accordingly, Tribal leaders should be involved in the direct formulation of services' provisions that would impact on their respective youth populations.

e) The development of separate curricula, to be applied to both juveniles and-as training tools to staff, administrative and law enforcement personnel, needs to occur. Many excellent units already exists that could render substantial, positive impact on this issue.

Accordingly, it is strongly recommended that entities, wishing to address this issue, first develop or propose a comprehensive cirriculum that would be applied to both juveniles and service providers, and that would stress the overall intent of prevention as the viable tool in curbing drug and alcohol abuse.

f) Expected outcomes in implementing methodologies that would address this problem, must be realistically stated.

Accordingly, it is suggested that projections as to the extent of impact, should be stated as part of a comprehensive proposal by providers in addressing this issue.

g) In reference to establishing summer recreation programs for Indian juveniles, it must be noted that the burden of such implementation is not a minor one.

Accordingly, guidelines need to be established as to the intent of such summer programs, projected outcomes, and impact to the servicing facility. Funding allocations must be cognizant of the need to compensate a facility that is utilized for such summer recreation projects.

h) Cost effectiveness, in provision of such treatment services, must be closely scrutinized. Duplication of services and the maximizing of effective methodologies, are issues that need to be addressed.

Accordingly, it is recommended that criteria be established as to the correlation of cost versus projected outcomes, and programs be closely evaluated based on such criteria.

i) Clarification as to the amount of appropiations, also needs to be addressed. For example, is the proposed $5 million a one time appropiation, or will this same amount be allocated in the subsequent years?

Accordingly, we urge this committee be deliniate both the amount and recurrence (if any) of such appropiations.

j) The Bill specifically mandates that Community Health Representatives receive "not less than two week of training on the problems of alcohol and drug abuse".

Accordingly, we recommend that Indian Health doctors, nurses, nurses aides, paramedical personnels, the Bureau of Indian Affairs Social Workers, and personnel of schools operated under PL-638 also be mandated to receive training on alcohol and substance abuse.

k) The Bill also specifies that certification be provided to any person who completes training under Title III of this Act.

Accordingly, we suggest that two issues be addressed regarding certification. First, that the content and contex of the training leading to certification be more specific, and, secondly, that all service providers in the areas of drug and alcohol abuse, also receive certification upon completion of the prescribed training.

Throughout the implementation of this proposed Bill, it should be further stressed that family involvement and the establishment of sequential (i.e., from fetal alcohol syndrome intervention, to headstart curricula, to classes throughout high school) intervention methodologies, are of key importance. We urge legislators to speed the enactment of this Bill, and to entertain the above suggestions and recommendations in rendering to this legislation the effectiveness necessary to fulfilling the Bill's instrinsic intent.

Giving the extremely important need to base all rehabilitative programs on sound and current data, we strongly suggest that, through the auspices of the Albuquerque Area, Indian Health Services, the All Indian Pueblo Council (AIPC) be contracted to conduct a study as proposed under Title V of this Bill; a study to be conducted by the AIPC's, Pueblo Health Training and Development Program.

The rationale for this proposal is based on three important factors:

a) The AIPC is the authorized entity entrusted to facilitate health deliveries to all of its Tribal membership.

b) The AIPC is the most logical entity to conduct the study through its data gathering network that includes members of the Pueblos' governance.

c) The AIPC has, in the past, conducted various key studies with a proven successful record in the gathered data's accuracy and pertinence.

With the above in mind, we urge this Committee to endorse the AIPC's willingness to conduct such a study to determine the number of juvenile Pueblo individuals needing alcohol and drug abuse prevention and treatment, to determine the number and access to existing facilities where such treatment could be provided, and to formulate accurate and cost-effective suggestions as to the level of funding required to conduct such treatment strategies for Pueblo youth needing such services. This Committee should also be aware that, presently, both the Bureau of Indian Affairs and the Indian Health Services have the resources available which could easily sponsor this proposed study. It is recommended that these agencies (at the local level), make these resources available to the AIPC as soon as possible. It is strongly suggested that the results yielded by this study, can facilitate the enactment of this Bill by underscoring the severity and prevalence of drug and alcohol abuse among Pueblo youth. Given the excellent record of the AIPC's ability to provide pertinent data in a timely fashion, this Committee's endorsement of such a study is strong[illegible]commended.

Again, let me thank this Committee for giving me the opportunity to partake in this hearing.

SOUTHERN PUEBLOS GOVERNORS COUNCIL
OFFICE OF THE CHAIRMAN

1000 Indian School Road, N.W. P.O. Box 1667 Albuquerque, New Mexico 87103

ACOMA
COCHITI
ISLETA
JEMEZ
LAGUNA
SAN FELIPE
SANDIA
SANTA ANA
SANTO DOMINGO
ZIA
ZUNI

TESTIMONY ON H. R. 1156

PRESENTED BY

GOVERNOR ALVINO LUCERO, PUEBLO OF ISLETA

JUNE 14, 1985

MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY TO BE HERE TODAY. MY NAME IS ALVINO LUCERO, GOVERNOR OF ISLETA PUEBLO AND ALSO CHAIRMAN FOR THE SOUTHERN PUEBLOS GOVERNOR'S COUNCIL, WHICH IS NINE PUEBLOS AT THE BIA'S SOUTHERN PUEBLOS AGENCY IN ALBUQUERQUE.

THIS IS THE TESTIMONY OF THE SOUTHERN PUEBLOS GOVERNOR'S COUNCIL RELATIVE TO H.R. 1156, THE "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT". THIS TESTIMONY WILL ADDRESS THE COUNCIL'S CONCERNS ON THE HANDLING OF INDIAN JUVENILE ALCOHOL AND DRUG ABUSE OFFENDERS, WITH SPECIFIC COMMENTS AND RECOMMENDATIONS ON H.R. 1156.

THE COUNCIL RECOGNIZES THAT THE ABUSE OF ALCOHOL AND DRUGS HAS DEVASTATING CONSEQUENCES IN NATIVE AMERICAN COMMUNITIES. THERE ARE TEN MAJOR CAUSES OF DEATH AMONG NATIVE AMERICANS, FOUR OF WHICH ARE DIRECTLY RELATED TO SUBSTANCE ABUSE: 1) ACCIDENTS, 2) CIRRHOSIS OF THE LIVER, CAUSING DEATHS AT ABOUT FIVE TIMES THE NATIONAL AVERAGE, 3) SUICIDES, AND 4) HOMICIDES. IN ADDITION, THERE IS A GROWING CONCERN OVER THE INCREASING EVIDENCE OF THE HIGH INCIDENCE OF FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT IN INDIAN COMMUNITIES.

IN ADDITION TO THE MORTALITY STATISTICS, ALCOHOL ABUSE IS KNOWN TO COMPLICATE SEVERAL DISEASES WHICH ARE PREVALENT IN NATIVE AMERICAN COMMUNITIES, SUCH AS DIABETES, CARDIO-VASCULAR CONDITIONS AND DIGESTIVE SYSTEM DISORDERS. AVAILABLE DATA ALSO INDICATES THAT

ALCOHOL AND DRUG ABUSE IS EQUALLY DEVASTATING UPON THE SOCIO-CULTURAL ASPECTS OF INDIAN COMMUNITY LIFE: REMOVAL OF THE CHILD FROM THE HOME; LOSS OF TIME FROM WORK DUE TO ILLNESS, INJURY, OR ARREST; MARITAL PROBLEMS; DOMESTIC VIOLENCE; CHILD ABUSE AND NEGLECT; AND POOR ACADEMIC PERFORMANCE. ESPECIALLY EVIDENT IS THE INCREASED USE AND ABUSE OF ALCOHOL AND DRUGS BY THE YOUNGER POPULATION. THE DISRUPTIVE AND DEVIANT BEHAVIORS ASSOCIATED WITH THE MISUSE AND ABUSE OF ALCOHOL AND DRUGS THREATENS THE STABILITY OF THE INDIVIDUAL, FAMILY AND COMMUNITY AS A WHOLE.

ACCORDING TO NATIONAL STATISTICS, IT CAN BE ASSUMED THAT 70% OF THE ADULT POPULATION DRINK ALCOHOLIC BEVERAGES AND OF THESE, ABOUT 3 OUT OF 10 ARE ALCOHOLICS. SECOND, MORE THAN 75% OF THE YOUTH DRINK AND HAVE USED DRUGS BY THE AGE OF 16; WHEREBY 60% OF HIGH SCHOOL SENIORS DRINK OR USE DRUGS ONCE A MONTH AND 25% OF THEM USE IT ONCE A WEEK. IN CONSIDERING THESE NATIONAL AND TRIBAL ADOPTED RATES, IT IS FAIR TO ASSUME THAT 33% OF THE ADULT POPULATION AND OF THE YOUTH POPULATION HAVE ALCOHOL AND DRUG-RELATED PROBLEMS.

SPECIFIC DATA COLLECTED FOR THE 1984 YEAR FROM ISLETA PUEBLO, ONE OF THE SOUTHERN PUEBLOS, DENOTES THE SERIOUSNESS OF THE ALCOHOL AND DRUG-RELATED PROBLEMS FACING ALL OF THE NATIVE AMERICAN COMMUNITIES TODAY.

ALCOHOL AND DRUG-RELATED PROBLEMS, ISLETA PUEBLO - 1984

1. ALCOHOL AND DRUG-RELATED ARRESTS AND CONVICTIONS ON ISLETA PUEBLO ARE 80% OF THE TOTAL ARRESTS FOR THE 1984 CALENDAR YEAR. (Source: Isleta Tribal Court and Police Department)

OFFENSE	MALES	FEMALES	JUVENILES	NON-INDIANS	TOTAL
TOTAL ARRESTS	193	8	16	40	255
ALCOHOL-RELATED:					
ARRESTS	152	7	8	7	174
DWI ARRESTS	54	4	0	6	64

2. INDIAN HEALTH SERVICE STATISTICS FOR 1984 DENOTE A TOTAL OF 34 PATIENT DAYS BY WHICH A BED WAS RESERVED FOR ALCOHOLIC PSYCHOSES/ DEPENDENT SYNDROME FOR CLIENTS FROM ISLETA PUEBLO.

   (Source: I.H.S. Area Planning and Statistics Branch)

3. THE ISLETA HEALTH CLINIC TREATED 47 PATIENTS IN 1984 ON AN OUT-PATIENT BASIS FOR ACUTE AND CHRONIC ALCOHOLISM.

4. THE ISLETA ALCOHOLISM PROGRAM HAS ON FILE (ADMITTED/DISCHARGED STATUS) A TOTAL OF 290 CLIENTS, WHEREBY FOLLOW-UP OR AFTERCARE HAVE BEEN AFFORDED TO THOSE NOT CONSIDERED IN THE PRESENT MATRIX OF 61. THESE CLIENTS WERE REFERRED TO THE PROGRAM BY EITHER SOCIAL SERVICES, TRIBAL COURT, CLINIC STAFF, OTHER COMMUNITY PROGRAMS, OR OUTSIDE AGENCIES AND COURTS.

5. MARITAL AND FAMILY PROBLEMS ARE OF SERIOUS NATURE DUE TO EXCESSIVE USE OF ALCOHOL OR DRUGS IN THE FAMILY BY ONE OR MORE MEMBERS. ACCORDING TO THE ISLETA SOCIAL SERVICE AND YOUTH COUNSELING PROGRAMS, IT IS ESTIMATED THAT 2 OUT OF 5 FAMILIES HAVE BEEN EXPERIENCING THESE PROBLEMS. WITH AN ESTIMATED POPULATION OF 3401, IT IS APPROXIMATED THAT 800 FAMILIES PRESENTLY RESIDE IN ISLETA, WHEREBY, A TOTAL OF 320 FAMILIES ARE SUBJECTED TO MARITAL/ FAMILY PROBLEMS RELATED TO SUBSTANCE ABUSE.

BASED ON THESE DATA AND CONCERNS REGARDING ALCOHOL AND DRUG ABUSE BY NATIVE AMERICAN ADULTS AND JUVENILES, THIS COUNCIL SUPPORTS ALL EFFORTS TO COMBAT THIS SERIOUS PROBLEM. IN PAST YEARS, ALCOHOLISM AND DRUG PROGRAMS PUT MUCH EFFORT INTO TREATING THE HARD-CORE ALCOHOLIC AND ADDICT BUT THE POSITIVE END RESULTS WERE MINIMAL. AS TIME PROGRESSED, THE UNSERVED POPULATION WHO HAD BEGUN DRINKING, PRIMARILY JUVENILES, CONTINUED THE CYCLE OF THE ILLNESS OF SUBSTANCE ABUSE. IT SEEMS TO BE A NEVER ENDING CYCLE. IT IS NOT ENOUGH TO TREAT ONLY THOSE WHO HAVE DEVELOPED A DEPENDENCE ON ALCOHOL OR DRUGS. IT IS OUR STRONG BELIEF THAT THROUGH EDUCATING THE FAMILY, YOUTH AND COMMUNITY

AT LARGE, WE CAN ADD TO THE PERSONAL AND SOCIAL GROWTH OF OUR PEOPLE, AS WELL AS CONTRIBUTING TO BREAKING THE CYCLE OF ALCOHOL AND DRUG ABUSE IN THE SOUTHERN PUEBLO COMMUNITIES. WITH THIS IN MIND, THE SCOPE OF WORK WITH SUBSTANCE ABUSERS WOULD LARGELY BE ENHANCED BY EDUCATION AND PREVENTION ACTIVITIES AND PROGRAMS.

ESPECIALLY EVIDENT AMONG NATIVE AMERICAN ADOLESCENTS TODAY ARE HARDSHIPS ASSOCIATED WITH MATURING, BOREDOM, PEER INFLUENCE, POOR SELF-CONCEPT, PROBLEMS AT HOME AND SCHOOL AND LACK OF SKILLS AND MOTIVATION, WHICH CREATE AN ENVIRONMENT FROM WHICH ALCOHOL AND DRUGS OFTEN SEEMS THE ONLY ESCAPE. PROGRAMS AND MEASURES WHICH WOULD FACILITATE THE ADOLESCENT'S TREATMENT BY UTILIZING PREVENTION, EDUCATION SERVICES, GROUP COUNSELING, FAMILY COUNSELING AND OTHER SERVICES COULD ASSIST THE ADOLESCENT AND FAMILY IN RETURNING TO A HEALTHY FUNCTIONAL LEVEL.

THE SOUTHERN PUEBLOS GOVERNOR'S COUNCIL SUPPORTS AND ENDORSES THE PROPOSED "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT", H.R. 1156, WITH THESE COMMENTS AND RECOMMENDATIONS:

1. SUPPORT OF TITLE I
2. SUPPORT OF TITLE II
3. SUPPORT OF TITLE III, WITH THESE RECOMMENDATIONS:
    A. TITLE III, 301 (b) (1) RECOMMENDATION THAT TRAINING SHALL BE MANDATORY, WITH A MINIMUM OF TWO WEEKS TRAINING ON THE PROBLEMS OF ALCOHOL AND DRUG ABUSE.
    B. TITLE III, 301,(c) RECOMMENDATION THAT PROVIDING CERTIFICATION SHALL ALSO APPLY TO AND INCLUDE ALCOHOL AND DRUG ABUSE SERVICE PROVIDERS.
4. SUPPORT OF TITLE IV
5. SUPPORT OF TITLE V, WITH THESE RECOMMENDATIONS:
    A. TITLE V, 501 RECOMMENDATION THAT THE STUDY INCLUDE TRIBAL INPUT.
    B. TITLE V, 503 (a) STRONG SUPPORT, AS THERE ARE PRESENTLY NO CENTRALLY LOCATED STRUCTURES FOR INDIAN JUVENILES.

THE STATEMENT OF JOE JOJOLA

ALL INDIAN PUEBLO COUNCIL ALCOHOLISM PROGRAM

Mr. Chairman, Ladies and Gentlemen of the Committee, Representative Richardson:

Thank you for inviting me here today, it is an honor and pleasure to testify before you on this most important issue.

It is appropriate for Congressman Richardson to arrange for the full interior committee to come to New Mexico. All nineteen of the Pueblos in our state as well as the largest proportion of New Mexico's Navajo and Jicarilla Apache population are located wholly or partially in the Third Congressional District. Issues of concern to New Mexico Tribes have been a high priority for Congressman Richardson.

Throughout these hearings, the Committee will receive considerable testimony on the total national picture of juvenile alcoholism and substance abuse. Today I would like to bring to the Committee information regarding the issues in New Mexico and the efforts made by the State and Tribes to respond to the social needs of Indian youth.

We recognize that the State has a direct interest in protecting and respecting the cultural diversity of its citizens. We are committed to working with the Tribes in a spirit of cooperation, coordination, communication, and good will. We realize that each Tribe has its own perspective on how the State should deal with social problems associated with juvenile alcohol and substance abuse.

We also realize that some Tribes have more highly developed social services systems than others.

The history of State/Tribal relations has too often been characterized by conflict. Jurisdictional issues, in addition to lack of coordination between Tribal social services and state resources, create gaps in delivery of services. This is particularly true in the area where the eastern boundary of the Navajo Reservation meets the State boundary in a checkerboard pattern of intermingled land ownership.

I have been told of an incident where an Indian youth in the checkerboard area assaulted another youth while under the influence of drugs. Because the Tribal treatment center to which he was referred was underfunded and understaffed and because that was the only facility in the area, this young man was jailed. He was later released without receiving counseling or treatment.

In an area where alcohol and substance abuse is significant, I fear that such incidents happen all too often. Much work remains to be done if we are to overcome traditional fears of jurisdiction dispute and the lack of resources necessary to deal with the effects of alcohol and drug abuse.

The New Mexico Human Services Department and the Tribes are making a significant effort to overcome such jurisdictional issues and to maximize use of limited resources. Our common goal is to protect Indian children and youth as well as to strengthen and promote the unity and security of the Indian family. Currently, the Human Services Department has 12 social services offices in the Third Congressional District which represents 41% of all social services offices in the State.

The Social Services Division is responsible through several titles of the Federal Social Security Act and several state laws to provide child care, family planning, foster care, protective care for children and adults, health support, adoptions and other services.

The Income Support Division has 12 offices in this district which represents 48% of the total income support offices statewide. The Income Support Division administers programs such as Aid to Families with Dependent Children, Medicaid, Food Assistance, Low Income Energy Assistance, and Child Support Enforcement.

The Department has also entered into specific service contracts with the Tribes to deliver social services. In the Third Congressional District, the Department has contracted with 11 Tribes in the areas of protective services to children, family services, and shelter care. We expect services to be delivered on a monthly basis to about 25 families and 98 children through the contracts.

Future efforts must emphasize the orderly transfer of jurisdiction, specify contact persons for the respective tribe and the Department, stipulate the conditions under which the

State and Tribe have a responsibility to act and what those responsibilities are. Through such formal agreements, a cohesive service delivery system can be developed with each Tribe having the latitude to develop its own services where appropriate.

It can be done. Although it has taken about a year to finalize, the State of New Mexico and the Navajo Tribe have developed a Joint Powers Agreement in the area of child protective services which clearly defines expectations and responsibilities for each party when dealing with a Navajo child either on or off the Reservation.

I hope this agreement will be a model for similar agreements with other Tribes. I hope it will be a foundation on which better state-tribal relations can be built.

We know that 11% of the total youth in the State are Indian. And while 36% of the State's general population are youth, 49% of the Indian population are youth. It is not unreasonable to surmise that a significant percentage of the Department's services are going to Indian youth in this Congressional District. Nor is it difficult to observe that youth services are of great importance to the Tribes when half of their population is under 21 years of age. And yet, I know that many needs still go unmet.

For example, in one case known to the Department, a young woman's life was devastated by alcoholism and its associated problems. Her father was alcoholic and physically abusive to her and other family members. As a means of coping with his alcoholism she too began to drink and by the age of 13 became an alcoholic. At the age of 15 she was a high school drop-out and pregnant. Her child was born with Fetal Alcohol Syndrome. She could not care for the baby physically or emotionally. Although she was eligible for

AFDC her lack of transportation and irresponsibility prevented her from using this service. The child was placed in temporary emergency foster care by HSD child protective service workers and was eventually adopted by a tribal family. This pattern continued to be repeated and by the age of 27 three more children were born and eventually placed with relatives or foster families. At 28 this woman was killed driving while intoxicated.

I can only conclude that while juvenile alcohol and substance abuse are serious problems for Indians throughout this District, these are problems that can be better dealt with through further cooperation and mutual respect between the State and Tribal Governments. I am aware that the State could do more to address this problem. However, in an era of constrained resources, it is incumbent upon us all to work together in maximizing our effectiveness in dealing with such social problems and in seeing to it that what needs to be done is done. I would urge that this body give some consideration to the problems arising from jurisdictional disputes and the resultant difficulty in delivering social services to New Mexico's Indian Youth.

Thank you for allowing me to testify before you. If you have any questions, I would be happy to address them.

IN REPLY REFER TO:

PUEBLO DE ACOMA
"THE SKY CITY"
P O Box 309
ACOMITA NEW MEXICO 87034

OFFICE OF THE GOVERNOR

TELEPHONE (505) 552 6606

GOVERNOR
Merle L Garcia
FIRST LT GOVERNOR
Fermin H Martinez
SECOND LT GOVERNOR
Harry Ascencio
SECRETARY
Dennis H Felipe
INTERPRETER
Dennis Lorenzo

TESTIMONY BEFORE THE
HOUSE INTERIOR & INSULAR AFFAIRS COMMITTEE
PRESENTED BY:
MERLE L. GARCIA, GOVERNOR
PUEBLO DE ACOMA
JUNE 14, 1985

On behalf of our Acoma people and the wonderful State of New Mexico, I am indeed pleased to be able to present this brief testimony before you today. We as leaders of our people and advocates for American Indians throughout this country are obligated every now and then to present our concerns and needs as expressed by those we serve.

As the traditionally appointed leader of my people, the Pueblo de Acoma, I can effectively relate to the many problems and concerns we are faced with during this time and age. However, unlike the elective process we are all so familiar with in becoming President of these wonderful United States, the leaders of the Pueblos are appointed by a system thousands of years old. The sacred group of our traditional religious society known as the Cacique bestowes upon selected individuals of the Pueblo the responsibility of leadership, sometimes against the individuals' will or desire. Nonetheless, we who are appointed, are very happy to be able to serve our people.

Many aspects of our way of life are unchanged and have withstood time, human intervention and yes even "Mother Nature". An outstanding example of this endurance is our famous pueblo, "Sky City". This Pueblo is the oldest continuously inhabited community in the Northern Hemisphere. The experience of standing in the midst of this living historic site is extraordinary and to many who have visited the site, feel the experience to be very spiritual. I know the spirituality of "Sky City" as being real and the endurance of my people is an example of what this great land can and will provide for all our people, Indian and non-Indian alike.

IN REPLY REFER TO:

PUEBLO DE ACOMA
"THE SKY CITY"
P. O. Box 309
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JUVENILE INDIAN ALCOHOL & DRUG ABUSE
PREVENTION ACT
H.R. 1156

Pueblo of Acoma is in full support of H.R. 1156, Juvenile Indian Alcohol and Drug Abuse Prevention Act.

Acoma has encountered many alcohol-related problems, and find it increasing with the closing of the uranium mines and cutbacks in federal funds, which provided employment to approximately 75% of the community members. Community people are getting frustrated seeking employment and finding none, and turning to alcohol to copo with stress; thus creating many unmanageable family problems.

True, Pueblo of Acoma has been working hard to implement private industries on the reservation to provide employment to it's community members, and have been successful to a certain degree; but, it does not accommodate all the members.

Pueblo of Acoma, Tribal Administrators have made numerous trips to Washington, D.C. to reestablish the Government to Government relationship by requesting both supportive assistance and monetary assistance. Again, we are requesting that favorable consideration be given to H.R. 1156, Juvenile Indian Alcohol and Drug Prevention Act, as the youth are the strength of our future.

The Act addresses interdepartmental agreements(Sec. 101-103), a vital asset, to reiterate the Government to Government relationship long ago established by our forefathers, and sidestepped throughout time.

Education (Sec. 201-206), another vital factor to combat the disease of alcoholism and drug abuse.

Family and Social Services(Sec. 301-a-c) Training in Alcohol prevention and involvement of all aspects of service providers will enhance the intervention of alcohol and drug abuse.

Law Enforcement (Sec. 401-402-B4), training for law enforcement personnel to identify alcohol and drug abuse problems with youth and providing safe placement in lieu of incarceration will allow a youth to learn to trust and respect law enforcement personnel.

Juvenile Alcohol & Drug Abuse Treatment & Rehabilitation, (Sec. 501-503c) Residential treatment facilities are a dire need in Indian communities especially in rural areas such as Acoma, where resources are minimal.

This Act will address our needs, if an Appropriation Bill is passed along with this Act, because without the funds, this will just be another Act without cause.

Again, we stress our support for this Act; and further, support an appropriation bill to accompany this Act.

Remember our strength as community and government represent strength for your government and community.

In closing, I would like to Thank you for allowing this time to present my testimony. I would also like to encourage you to view our requests in a positive manner and trust you will do all that is in your power to ensure that the trust responsibility to the American Indian by the Federal Government is carried out. If there are any questions, I will be glad to answer them. Thank you.

Respectfully Submitted:

Merle L. Garcia
Governor

cc: NM Congressional Delegation

TESTIMONY OF THE NAVAJO TRIBE
PRESENTED TO
THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
ON H.R. 1156
INDIAN JUVENILE ALCOHOL AND DRUG ABUSE
PREVENTION ACT

June 14, 1985

Mr. Chairman, members of the Committee, I appreciate the opportunity to appear here today to present to you the concerns of the Navajo People regarding the proposed legislation entitled the "Indian Juvenile Alcohol and Drug Abuse Prevention Act"

We congratulate Congressmen Bereuter and Daschle efforts contained in H.R. 1156. We also appreciate Congressman McCain's efforts contained in H.R. 2624. We are pleased to see that this issue is receiving the Congressional attention necessary to help us address the alcohol and drug abuse problem among our Indian youth.

Alcoholism has been identified by the Health and Human Services Committee of the Navajo Tribal Council as the number one health and social problem in the Navajo Nation which has had or is having an adverse impact upon virtually every member of the Navajo Tribe.

No extensive research has been undertaken to determine the causes. However, the following factors as stated in the Navajo Master Health Plan must be considered as contributing factors to excessive drinking on the Navajo Nation. "Disruption of the traditional way of life, proverty, unemployment, low level of education, political and social constraints on social mobility and the lack of self-esteem" have all effected the abuse of alcohol. The unemployment rate is increasing and approximately half of all Navajo families lived below the poverty level in 1980.

Five of the ten leading causes of death among Navajos (IHS 1978) were related to alcohol abuse - accidents, chronic alcoholism, cirrhosis of the liver, homicides and suicides. These five catagories accounted for 370 Navajo deaths, or almost 45% of all Navajo deaths for that year.

Accidents alone accounted for 256 deaths, approximately 30% of all Navajo deaths in 1978. In comparison, only 5% of all deaths in the U.S. were caused by accidents. In 1982, approximately one-third of all injuries sustained in motor vehicle accidents were alcohol-related.

Many acts of violence on the reservation are alcohol-related. In 1982, over half the injuries caused by assault were committed under the influence of alcohol. Fifty seven percent (57%) of children seen at IHS medical facilities and classified as "battered" were victims of an alcohol abuser. In 1982, 43% of all suicide attempts were alcohol-related. A reservation-wide survey conducted in 1979 indicated that alcoholism and alcohol abuse are the main factors influencing many of the psychological and socio-economic suffering experienced by many Navajo families. Alcoholism contributes to marital disruption, loss of employment, child abuse and neglect, rape and spouse abuse. Severe emotional and educational problems are surfacing among children of alcohol abusers; indeed, alcohol, drug and inhalent abuse are seen as significant problems among Navajo youth.

Other impacts on Navajo children and families are harder to chart statistically. Children of alcoholics are now recognized as suffering from emotional handicaps, feelings of guilt and depression, an inability to trust, and an inability to establish close personal relationships. Children of alcoholics are four times more likely than their peers to engage in alcoholic drinking and become chemically dependent. These children are disproportionately at risk of having adult lives that are impaired by chemical dependency or by their relationship to chemically dependent people.

Statistical data and information on the nature of the substance abuse problems among Navajo youth demonstrates that substance abuse is comparable, or rapidly catching up with the rest of the nation. Based on a 1983 survey of 100 5th and 6th graders from five schools representing a cross section of the Navajo Nation: 30% had used alcohol; 48% had used tobacco; 23% had used inhalents; and 15% had used marijuana. A national study on Native American youth by Colorado State University presents alarming evidence for the time period from 1975 - 1983. Fifty-three percent of Indian youth would be classified 'at risk' in their drug involvement, compared with 35% of non-Indian youth. Forty nine percent (49%) of our Navajo population is at or below the age of 19. The median age for Navajo population is 19.8 as opposed to the median age of 30 for the general American population. It is a conservative estimate to say that at least 25% of our Navajo youth experience substance abuse problems. The great cultural instability experienced in recent years has produced numerous and devasting social and family problems which result in problems with identity, self-image, self-esteem and motivation for Navajo youth. Thus, Navajo youth are at higher risk than the average American youth.

The Navajo Nation is addressing the problems of alcohol, drug, and inhalent abuse among adolescents with the very limited resources that are currently available. The Youth Education on Substance Abuse Program is involved with four components that address youth services which are: 1) developing a culturally appropriate alcohol and substance abuse curriculum for incorporation into existing school health education curriculum (K-12) in public, BIA, and private schools; 2) developing community-oriented education programs on the prevention of alcohol and substance abuse; 3) establishing an alcohol and substance abuse program to teach and implement an early identification and referral system to school staff, as well as developing a program of training for school staff to help them develop the most effective means possible for dealing with substance abuse among the students; and 4) establishing a Substance Abuse Resource Center. The Tuba City Adolescent Substance Abuse Program, an outpatient program, is a community-based program which works with the schools in coordinating prevention, early intervention and treatment services. In early June 1985, the Navajo Alcohol Program (NAP) opened the Twin Trails Treatment Center, located in Chinle, Arizona. This is the first adolescent residential facility on the Navajo Reservation. All field offices of NAP have counselors that provide ancillary, but not specialized, services to youth.

A brief look at the recent history of disease trends among our people provides ample evidence that (1) prevention and promotion activities have had a major impact on Navajo health status and (2) emerging patterns of illness and disability can be effectively addressed through prevention and promotion efforts.

We view the proposed legislation as part of the Federal trust responsibility. Eligibility for such benefits must be determined by on a government-to-government basis with incontrovertible legal, moral and ethical foundations, as defined by the Snyder Act of 1921, P.L. 93-638, the Indian Self-Determination Act, and P.L. 94-437, the Indian Health Care Improvement Act.

There are several issues in H.R. 1156 that we would like to highlight. These issues are:

1. Interagency Agreement

It is recommended that the Office of Indian Juvenile Alcohol and Drug Abuse be placed under the administration of the Indian Health Services. I.H.S. is currently the Central agency involved in funding the Indian alcohol programs.

2. Tribal Government Involvement

We strongly recommend legislative language to ensure that tribal governments will have pronounced authority in the development and implementation of this Bill. The legislative intent may be protracted if it is the responsibility of Indian Health Service and the Bureau of Indian Affairs. An example of this recommendation can be seen in the preamble and intent of the Indian Child Welfare Act of 1978. This Act exemplifies recognition by Congress in validating the role of Tribes in determining their own destiny with their prevailing cultural standards. That Act stated, "Let's do it the way Indian people and Tribal traditions mandate", thus recognizing Tribal sovereignty. Only a limited number of federal and state legislation on Indian matters have had such a broad vision.

3. Family Participation

We recommend the bill place more emphasis on family particiation. Assimilation over the decades has weakened and presently threatens to eliminate the traditional Navajo family and clan system. It is important to focus on the adolescent as a member of the family rather than as an isolated individual, first from the traditional perspective and second, from the Western treatment modality perspective across the country. For example, parents are the most involved with youth, schools and the community. Parents, if adequately informed and trained, can prevent, intervene and treat adolescent substance abusers. This is widely recognized by professionals in behavioral health fields.

4. Title Of Bill

We recommend inserting "and inhalants" after the word "drug" in the title. The use of inhalants is becoming widespread and common for adolescents, and adults.

We also recommend replacing "Juvenile" with "Adolescent", as the popular connotation of juvenile implies someone who is a delinquent or "problem". Prevention would address individuals before the problem becomes severe enough to involve contact with the judicial system. The Title would read "Indian Adolescent Alcohol, Drug and Inhalant Abuse Prevention Act."

5. Training

H.R. 1156 is comprehensive in specifying who should receive training on adolescent substance abuse. However, we would urge two other groups be included: first, the Indian families who will provide foster care. These families will be responsible for providing temporary emergency shelter. This training could be handled under the standards that the Bureau of Indian Affairs will establish for licensing. It is not enough to have the individual supervising such a shelter to be trained. The families providing shelter will be encountering troubled youth and it is imperative that they be properly prepared. Second, we also recommend including parents in the training and instruction.

Training must include the Indian perspective on Child Development, Sociology, Psychology, preventive stategies and family living. In addition the training programm should allow provisions for Tribal elders to provide their knowledge of treating depression, anxiety, child abuse and neglect, spouse abuse and alcohol, drug and inhalent abuse. Their knowledge could improve and promote services to the tribes.

6. Access to recreation and counseling

While the proposed legislation mandates year round use of BIA and contract schools, numerous communities do not have access or are near such school facilities. The Navajo Nation recommends that other facilities be made available to these communities.

7. Law Enforcement

Referrals made by the law enforcement officers should be in accordance, where applicable, with existing Tribal Juvenile Codes.

In addition to the referral sources available, the Navajo Nation recommends that medical facilities be included in the list of referral sources.

The Navajo Nation recommends language be included that the law enforcement officer arresting an adolescent under the influence be referred to a detox facility rather than a residential treatment facility. Potential harm may be generated by mixing adolescents in residentiail treatment with those who are being detoxified. Moreover, the Bill should distinguish those adolescents arrested for criminal activity as opposed to those arrested for being under the influence.

All adolescents cannot be served efficiently outside the immediate family environment. Language should specify that not all identified youth can be placed in residential treatment centers. A more effective casework plan can include home visits with Juvenile Justice system leverage. Not only would some adolescents be running away from residential facilities, but residential facilities may be inappropriate for the youth and his/her problem.

8. Access to existing Indian Health Service Facilities

Require I.H.S. Service Units to survey the number of beds that could be used for detoxification of substance abusers. If such beds are not currently available, I.H.S. would work with tribal programs who would recommend the increased number of beds. In conducting such planning, attention would be focused on differences in treatment needs between adult and adolescent patients.

Traditional people have always used each natural substance for a specific application. Natural substances were consumed for spiritual and medicinal reasons and use was restricted to specific functions. This misuse by tribal people was universally viewed as a violation of the natural order of things. A world view that incorporates balance and respect for purposeful behavior holds virtually automatic safeguards against substance abuse.

Navajo traditional ways recognize the importance of taking measures to prevent illness and promote healthy life-styles. Man's path is called "the corn pollen path" by our elders, symbolizing a balance and harmonious existence. The goal of healthful living is "se ahnaghaii Bei Kee Hozhon", the essence of harmony. Harmony is health. Harmony is beauty. Harmony is happiness.

I would like to thank the Committee for allowing the Navajo Tribe to present their views on this important legislation. I would be happy to answer any questins the Committee may have at this time.

TESTIMONY FOR: HEARINGS ON HR-1156
JUVENILE INDIAN ALCOHOL AND DRUG ABUSE PREVENTION ACT

CHAIRED BY: CONGRESSMAN BILL RICHARDSON

PRESENTED BY: BENNIE COHOE, EXECUTIVE DIRECTOR
RAMAH NAVAJO SCHOOL BOARD, INC.
PINE HILL, NEW MEXICO 87321

DATE: JUNE 14, 1985

LOCATION: ALBUQUERQUE, NEW MEXICO

Mr. Chairman and members of the committee, my name is Bennie Cohoe and as Executive Director, I represent the Ramah Navajo School Board for these hearings. Let me first thank you for this opportunity to provide input and for your evident concern on a matter of utmost importance to all Native American communities.

The Ramah Navajo School Board is most gratified that Congress has recognized a critical and life threatening problem facing our children and has attempted to address this problem in this proposed legislation. We do strongly support the efforts of Congress and the intent of this legislation.

However, we are concerned that implementation of this legislation, as written, may have unforseen and undesired results including: potential conflict and administrative overkill among federal agencies; threatened funding stability of quality programs already in-place; and is unlikely to lead to significant improvement if the problem due to inadequate level of funding proposed.

The Ramah Navajo School Board and Community are in the unique position of having "pilot-tested" the concept of this legislation: as a P.L. 93-638 Contract School Board, we administer an IHS clinic; BIA Social Services program; and comprehensive educational programs.

Through the coordinated efforts of these programs we have been able to address some of the critical needs of our community, including preventive intervention programs for our youth. Yet, our experience has taught us that coordination (or a directive from Congress) does not mean results -- the bottom line is the lack of adequate resources to make a significant impact on a situation of generations of neglect and socio-economic malaise.

We are concerned that without adequate additional funding, the requirements of this legislation may lead to reductions in funding levels for in-place programs. Though we recognize the importance of preventive programs, we are faced with the reality that there is a continuing need for acute care and treatment of existing problems. So far this month alone, our clinic has treated 10 cases of accident and trauma that were alcohol related and in the last four month period, over 38 alcohol related cases were handled by our Social Services program. Safeguards to protect the level of funding -- that is barely sufficient to meet current basic needs -- must be part of this legislation.

Though this legislation calls for coordination and a "pooling" of resources among agencies, history has shown us that, what happends instead, is the dollars are spent on new layers of administration and few dollars reach the field. The administration of 638 contracting by the BIA is a prime example of this.

We ask the committee to consider the following recommendations:

1. Increase, dramatically, the proposed level of funding for this legislation in order to effect the intent to meet a critical need.

2. implement the law in a phased-in-manner that will avoid chaos and prevent diversion of funds from important in-place programs;

3. provide for a number of "demonstration" projects where administrative procedures can be developed; appropriate training and curricular materials be developed; and programmatic approaches be developed and tested. These projects, then, can serve as models for implementing the law on a national scale; and

4. provide specific language prohibiting the BIA and IHS from diverting funds from existing programs such as clinics, the CHR program and Social Service programs to the implementation of this legislation.

Again, let me thank the committee for its time and consideration and let me reaffirm our strong support for the intent of this legislation. I ask the permission of the committee to submit more detailed, written testimony at a later date. Thank you.

Testimony

H.R. 1156

Juvenile Indian Alcohol and Drug Abuse Prevention Act

Prepared and Presented
by
The Albuquerque Area Indian Health Board, Inc.

Albuquerque Area Indian Health Board
5600 Domingo, N.E. / Albuquerque, New Mexico 87108 / (505) 268-4591

We represent the Albuquerque Area Indian Health Board, Inc. and are here to testify on behalf of the tribes and communities represented therein: the Jicarilla Apache Tribe, Mescalero Apache Tribe, Alamo Navajo Chapter, Canoncito Band of Navajos, Ramah Navajo Community Chapter, Southern Ute Tribe, Ute Mountain Ute Tribe, and off-reservation populations within the Denver and Albuquerque metropolitan areas.

A 1976 study conducted by the Alcoholism Council of Orange County, California showed that two thirds of the 2,500 polled-ages seven to twenty-one had reached "drinker status". This is identical to the drinking rate among adults in a 1965 study. The same survey showed a four hundred percent increase over the youth drinking patterns since 1964.

As of 1983, sixty percent of the people killed in drunk driving accidents were teenagers. Nearly 20,000 are killed annually because of drunk driving. National suicide rates among grade school younsters have risen sharply. Depression has been cited as the major reason for these pre-teens taking their lives. Alcohol is a depressant drug. Of the children interviewed by the Orange County Study, nearly twenty-six percent have reached problem proportions in their drinking. The suicide rate for alcoholics is 58 times that of non-alcoholics.

Americans consumed 4.6 billion gallons of alcoholic beverages in 1976. 95 million Americans were drinking alcohol that year. If we add the increase in the number of drinkers since then, the figures are startling.

Young alcoholics come from all classes of our society, from both sexes and all ethnic groups. But to these shocking statistics add the fact that Native American youth have the highest proportion of heavy drinkers and these are statistics that understate the dimensions of the problem.

In some of our communities children are drinking at the ages of 6 and 7. Many are already into inhalants by the age of 4. In the ages 13-19 around 80% are reported drinking. Most suicides among Indians are alcohol related and so are most accidental deaths. 90% of all crimes committed by Indians are alcohol related.

The alcoholic and problem drinker affect every aspect of the community life - its welfare, health, family, economy, education and so on. When we think of all the pathology that an alcoholic community experiences - suicide, homicide, child abuse and neglect, poor productivity, low educational outcomes, etc. - the magnitude of social decay is astounding. The worst tragedy is that the prevalence of this destructive behavior in some Indian communities has become not only tolerated but socially accepted.

The reason for this acceptance is that alcoholism creates a family behavior dynamics that impacts on every person in that family or somehow connected to it. The behavioral adaptations to the pathology is what the jargon in the field of alcoholism has called co-dependency. So we are dealing not only with the alcoholic behavior of a large segment of the population, but with co-dependent behavior of entire communities.

While we agree that there is an urgent need to address the problems of adolescents, we feel that it must not be addressed in isolation.

Therefore, in the following pages we will delineate first the complex historical setting in which we are working, then the approach and focus we are taking and finally, we will comment specifically on the provisions of H.R. 1156.

INTRODUCTION

Historically, well-integrated, well-developed societies have produced well-integrated families and individuals who derive satisfaction, positive self-identity and meaning for their lives from the balance and security they experience. The individuals and families of these societies are generally mentally and physically healthy and experience very low rates of such social pathologies as substance abuse and addiction, suicide, crime, divorce and child abuse. On the other hand social disorganization, rapid cultural and social change, cultural, economic, political and social conflict result in interpersonal stress, confusion, alienation, despair and depression. These in turn may appear in the form of crime, suicide, addictions and numerous other dysfunctions.

Research both within and outside the Indian communities demonstrates that this same universal phenomenon applies to Indian people today. The acculturation dilemma that many tribes and their members face is raising the rates of dysfunctional behavior. Tribes are undergoing rapid social and cultural change. These changes are encroaching on every aspect of Indian personal and community life. Studies done thus far specifically link school failure, alcoholism, suicide, crime and early pregnancy to this dynamic of change. In order to address the dysfunctions that result from this rapid change we must address the issue of social, economic, political and cultural development of communities.

Most people think of development and modernization in terms of political power and economic enterprising. Often this is done by modeling solely the American capitalist free enterprise system. What is not often understood is that without the social and cultural development of the people these political and economic dynamics only make them more susceptible to the vulnerability of alienation, disintegration and sense of meaninglessness of their existence and therefore, of the destructive behaviors. Economic development though very important must be integrated with the social development of the people.

Only those who are part of well-organized communities where a sense of belonging is strong, whose interpersonal relationships are stable and well-integrated, and whose values are clear enough to allow them the judgmental skills necessary for good decision-making can then make the choices for economic enterprising that will affirm a high quality of life for themselves and their communities.

Only children who have grown in families and communities which have provided that type of integration can become successful in their school or academic performance or in the general and significant acquisition of knowledge. Success in this realm has a significant risk-reduction effect in their adult lives in the world of political leadership, economic enterprising, social and cultural contribution and personal satisfaction. With this understanding in mind, a comprehensive alcoholism prevention effort must consider a wholistic look at the communities. Both the approaches and the foci must include a multi-pronged way of addressing the entire community.

APPROACH AND FOCUS

Alcoholism is a problem that impacts communities around the world. In the United States, there has been a revival of concern over its effects. And while alcoholism has severely affected Indian communities for several generations, it has only been recently that any concerted attempt to deal with the issue has emerged. There is great hope that the national concern over the impact of alcoholism and drug abuse coupled with the special concern felt by Indian communities will provide the impetus, direction, and alliances necessary to win this war against alcoholism.

The issue of alcoholism prevention is multi-faceted. There are however, two basic aspects into which the many facets will fit. Those are the approach and the focus. The focus should be broad based. And the approach should meet the needs of different target populations.

Currently many people are concentrating on the individual in their prevention efforts. Self-esteem, skill development, getting in touch with yourself are catch words and concepts in the individual focused approach. But such direction is one-sided. A person's self-esteem and self-worth are integral to the community. They are found and reinforced in one's relationships within the family and community, and in one's work. If these efforts are not focused on the community as well as in the individual, the person ends up with a false sense of self-esteem and self-worth that are not reinforced in their daily relationships in the community. Such a fragile shell of self-esteem is easily shattered and much harder to repair once it is broken.

The same is true for the prevention program that is solely focused on community development. Without developing the individuals, community development projects can only fail because those who are to participate and control the projects may be suffering from untreated alcoholism or co-dependency. Their judgment may be impaired and their relationships in the community may be stigmatized. Thus, in order for the totality of the problem to be addressed successfully, alcoholism prevention must have both a collective and a personal development focus.

There is also the question of the approach to be taken. When one considers that there are basically three groups of people in relation to alcoholism: Those who appear to be functioning well; those who are obviously sick from the alcohol; and those who are chronically ill, one can see that the efforts must be able to meet the needs of each group. Thus this approach should be three pronged: Primary Prevention geared at creating a healthy environment for all people; Identification and Intervention for those obviously sick or at high risk of becoming sick; and Treatment for those who are chronically ill.

Each prong has a different target population, and thus requires different programs. The primary prevention prong deals with socio-economic development as well as personal development of people in an environment that promotes wellness. This wellness model must be conceptualized as the reintegration and development of communities through the socio-economic growth of individuals, families, and the systems and structures which are there to serve them. The target population includes children, parents, and families who are not using alcohol or drugs as well as the environment in which they live. The programs should be oriented to insure that children and young adults have the chance to develop the following essential skills:

1. Identification with viable role models;
2. Identification with and responsibility for family processes;
3. Faith in personal resources to resolve problems;
4. Adequate development of intrapersonal skills;
5. Adequate development of interpersonal skills;
6. Well developed situational skills;
7. Adequately developed judgmental skills.

The development of these skills will provide children with the ability to deal with the world without having to resort to drugs or alcohol to soothe their hurt or escape from life. At the same time, the social, political, economic and cultural aspects of the community must be addressed from the point of view of allowing the full development of the individual to insure that he/she will be able to maintain that sense of self worth in an environment that promotes personal, economic, cultural, and general social development.

The target population for the early identification and intervention prong includes those who are using alcohol and drugs to an extent that their personal lives or the lives of others around them are beginning to be impacted by the use. Problems at work, at school, with the legal system have begun to show up. But they also provide a point from which to intervene in the cycle of drug and alcohol use. They provide a basis for work with the individual and the community to resolve alcoholism and drug abuse issues through the work or school environment, the legal or health systems or any other situation within which people function.

The third prong is directed to the chronic, often called end-stage client. This is the client that is very ill from alcohol and drug abuse and for whom employment, family, and other aspects of community life have little or no meaning. Yet failure to adequately treat these clients will continue the cycle of alcoholism in the community.

Thus, when speaking of Primary Prevention, what is actually being addressed is community and personal development and therefore, it is important to address the following:

1. Stabilization of families through effective parenting skill development, education of the entire family on issues of personal growth, child growth and development, importance of social and community involvement, integration of the school activities with community and national realities, communication, values clarification, affirmation of traditional activities that will contribute to a positive self-identity perception as well as the incorporation of skill development necessary to function comfortably and well integrated with the modernization process.

2. Because the Indian population is basically a young group, it is necessary to make an all out effort to give children and young people the skills necessary to function well in the modern world as well as the pride they need for their sense of self-identity based on their roots and heritage. These skills include positive and viable role models on which to base their behaviors and goals; seeing themselves as significant contributors to their families, their schools, their communities and the nation; perceptions of themselves as effective problem solvers; ability to deal with themselves intrapersonally; ability to deal effectively in their interpersonal relationships; well-developed situational and judgmental skills. These skills can only emerge within family, school and community settings. Parents need assistance in developing these skills themselves in order to pass them to their children. Teachers need to develop them

as well and able to incorporate them in their curricula. Adults have to view themselves as socially responsible for what happens to the children of their communities. Advocacy networks must be developed on behalf of children to assist them with and defend them before the difficulties they encounter whether at home, in schools and the communities in general. Some children need academic assistance; some need social assistance; some need a friend; some need an advocate who can help them with problems of physical, emotional or sexual abuse, problems of neglect or racism or the many other difficulties they face in growing up. Mentoring systems need to be incorporated into the schools. Children need guidance in making choices both for the present and for the future. Many need to even learn to develop goals for themselves and then how to strategize for the achievement of those goals.

3. Efforts toward tighter cultural integration of the communities is necessary. This must include a selection of significant traditional values and skills in balance with modern values and skills. The mission of this integration is to offer the people a viable social structure in which they can find meaning and security in their lives as they must live them within the context of today.

4. Economic development should not be viewed as simply a means to make dollars and acquire jobs and material goods. Technologies appropriate to the environment must be sought. The protection of the land, the water and the natural habitat is of upmost importance if we are seriously considering the future generations. Jobs should not just offer a pay check, but personal gratification as well as a sense of social contribution to the community. Many tribes have introduced or allowed to have others introduce economic activities to their communities that will bring them dollars in the short run, but that in the future will create serious social problems as well as the destruction of their land, water and other resources.

5. The Indian communities need strong, knowledgeable, wise, and courageous leaders. Uninformed, uneducated, fearful leaders are a disaster for any group. There are serious decisions to be made and often this is scary. Risk-taking is not comfortable but it is part of the necessary approaches to life and growth. The development of this kind of leadership must be an integral part of the development of any community.

In sum, when speaking of Primary Prevention or community development, it is essential to address the following:

1. Stabilization and strengthening of families.
2. Improvement of the relevance and outcomes of the education of young people and development of the seven basic skills among the entire population.
3. Clarification of values and beliefs which will permit the development of clear tribal goals which will be achieved through the integration of the best and most useable tools and understandings of the traditional and modern worlds.
4. Economic development which is appropriate to the environment, culture, skills, wellness and goals of the community.

Early Intervention with Early Identified clients and Treatment for chronic patients must be addressed simultaneously with the primary prevention strategies. Early Intervention with alcohol and drug problems involves identifying individuals and families at high risk for problems and referring them for evaluation and treatment at the earliest appearance of symptoms. The concept also involves reorienting treatment programs to deal with these individuals and families in the earlier stages of chemical dependency. Certain institutions or agencies in our society are ideally suited to initiate early interventions because they add a measure of enforcement to the weight of a referral, thereby countering the resistance of an individual to seek help common to the disease.

Aspects of a successful Early Intervehtion should include the legal system, the workplace, the school, and the health and social services. With regard to the legal system strict enforcement of existing alcohol and drug-related statutes in all jurisdictions, both tribal and non-tribal is of primary significance. The court ordered screening of all offenders suspected of alcohol or drug involvement should include a thorough assessment and recommendations for appropriate treatement. Screening should be mandatory for all cases where drug and alcohol involvement is a given, i.e., driving under the influence of intoxicants, public drunkeness, minor in possession of alcohol, etc. and available at the discretion of the court for other offenses. Requiring referrals to treatment as part of the probationary stipulations of convicted offenders who have been determined to be in need of treatment by a qualified screening program should also be included as a major effort.

In terms of the workplace support for a nation-wide emphasis on the establishment of Employee Assistance programs by employers in both the public and private sector represents a powerful tool. In particular, the establishment of effective programs for all federal and tribal employees should be encouraged. Employee Assistance programs have been developed as a response to the need of businesses, agencies, and other employers to rehabilitate workers and managers who have personal problems severe enough to reduce their job performance. Successful programs are based on the following assumptions:

- Alcoholism and other personal problems such as marital discord, financial and legal difficulties, and mental or emotional disorders, should be regarded as medical problems in the workplace.
- The best method for identifying these personal problems is the supervisor's awareness of impaired work performance.
- Confidential sources of evaluation, referral, and treatment should be available to all affected employees on a voluntary basis, whether or not they have been referred by a supervisor. Services should also be made available to the members of an employee's family.
- Regular disciplinary action for poor work performance should be suspended while the employee conscientiously seeks help for his/her problem.
- Returning to adequate job performance is the primary measure of successful outcomes.

According to the Fourth Special Report to the U.S. Congress on Alcohol and Health (U.S. Department of the Health and Human Services, 1981), Employee Assistance programs appear to be the most widely used method for intervening with alcohol and drug-related problems in our society. They are also proving to be successful at what they do: "Cost-benefit studies of Employee Assistance programs generally support the claim that productivity losses attributable to alcoholic employees can be reduced" (Fifth Special Report, 1984).

Schools are a very important setting for the early identification and intervention approach. The adoption of Student Assistance programs in schools to provide for the identification, evaluation, and referral to treatment of students experiencing academic or disciplinary problems related to the use of alcohol or other drugs by themselves or other members of their families has to be an intricate part of the school services and of the effort to arrest alcohol and drug usage.

Training and networking of health and social service providers in all communities to be able to identify and effectively deal with problems related to alcoholism, other forms of chemical dependency, and co-dependency (i.e., the effects of the disease of chemical dependency on those who encounter it in someone close to them) is necessary if the goal is to get to everyone affected. Again, the emphasis should be on intervening with whole families as well as individuals with every effort made to keep families together.

None of these efforts deal with the treatment of the chronic alcoholic. Yet this group must be addressed as well. While the reorientation of efforts in our society toward primary prevention and early intervention with individuals and families, must be supported, it is also necessary that those people diagnosed as chronic alcoholics or substance abusers should be given the opportunity to obtain high quality treatment and to return to communities which support an environment of recovery for both the individual and the family. Rather than simply being sent to so-called "revolving door" programs for custodial care, it is recommended that such individuals should be able to participate in intense family-based treatment programs before they are dismissed as hopeless.

In addition, it is important to support the funding of 24-hours detoxification facilities wherever feasible as an alternative to jail or death by exposure. Such facilities should be part of a continuum of care which will allow them to interact effectively with police and emergency services and then make appropriate referrals for treatment beyond detoxification.

Effective professional alcohol and drug treatment programs for individuals who are incarcerated is also necessary in order to get at all groups which in one way or another will eventually have their impact. It would be comfortable enough to say that this three pronged approach at the individual and community level will take care of the problem. Unfortunately, that is not the case. Our own obversations and all reports and studies on substance abuse by adolescents and young children show an alarming increase in regular use pressured by their peers and the messages they get on a regular basis from all the institutions that form our beliefs and behavior. These observations and statistics reveal profound risks to both the evolution of human relationships and human physiology. Therefore, carefully strategized intervention at several levels is required if we are to truly influence the future impacts of this trend.

It is important to remember that each person develop unconscious beliefs that are largely formed early in life, are strongly influenced by cultural patterns and are unconsciously held collectively. Even when these beliefs are disadvantageous to individuals and groups, there is strong resistance to changing them. The media, for example, is one powerful way of developing this individual or collective unconscious information.

The use of television advertising by the liquor industry puts a powerful image of alcohol use in nearly every American home, teaching children at early ages that alcohol is desirable and even essential for social interaction, for celebration, enjoyment of leisure and to affirm prosperity. One billion dollars annually is spent by the liquor industry for this advertising. To delegitimize this image of alcohol as a part of the social reality of leisure, sport events, rodeos and evidence of personal ease and prosperity this advertising must be eliminated as it is clearly injurious to children and young adults.

With the current epidemic of alcohol-related illnesses and problems of young people in America and the intensity of this dilemma for Indian people, action must be carefully planned and given priority.

There are a multitude of things that can be done. Some require supporting efforts that are already in existence and that others have already led for us. For instance:

- The National Coalition of organizations and individuals who in 1984 began to petition the television and radio broadcasting companies to eliminate liquor advertising must be supported by all those who are concerned about this psychological brainwashing.
- Another strategic plan could include a community effort to change collectively held beliefs and messages about the desirability of alcohol at community sports and events. One way to start is by eliminating liquor industry sponsorship of any event. Instead, sponsorship that emphasize health to promote healthy activities can be utilized.
- One other approach could deal with drinking age. The minimum age drinking laws can be standardized nationally at age 21, as another powerful statement that the risk of addiction and its detrimental health effects to young people are too great to legitimize drinking at any younger age.

Finally, communities need to carefully assess the impact of alcohol and drug-related behavior on family stability, job and school performance, judical decisions, health costs and economic priorities. By using community profile or assessment tools to produce a clear picture of the effects of alcohol and drugs, action steps can be planned and implemented to overcome the resistance to change of beliefs and values on alcohol use. This kind of problem oriented research must be designed in such a way that it will make it possible for the community leaders to evaluate alternative policies and programmatic planning and implementation techniques.

Through a clear picture of what the community faces and its options to change those conditions a strong leadership willing to take the risks to go after those optimum conditions will become very effective in overcoming the resistance to change that comes as a result of the bombardment of messages the unconscious fears and the vested interests of individuals, and or groups.

In sum, the mission of an effective strategy to deal with the issue of alcoholism must be to produce well integrated individuals, families, and communities where satisfaction and positive self-identity and meaning for their lives emerge from the balance and security they experience.

The approach must be multifacetic; thus addressing the environment through controlled and carefully planned change as well as the stabilization of individuals and their families. Since change is going to occur anyway, it is important to control it for the well-being of the people who will be affected. To control change does not mean to hold back. It means to steer it in the direction that will promote the wellness of the people who will be living it as well as creating the healthy environment in which they will flourish.

Provisions H.R. 1156

For the purposes of this testimony we have grouped the provisions of H.R. 1156 into categories that will permit concise comment.

I. Resource Sharing and Coordination

This is a critical consideration and should be strictly adhered to not only among the BIA and IHS, but with their contractors, tribal schools and state programs. It must be understood, however, that it is not merely issues of "territoriality" which impedes cooperation and resource sharing but rigi[illegible]ing agency policies and regulations.

II. Indian Education and Counseling

Provisions which permit drug and alcohol counselling should instead require it. At the very minimum, Indian education program staff should be trained in the early identification of alcohol and drug problems and should have appropriate referral resources for intervention and treatment.

III. Schools as Recreation and Counseling Centers

The opening of schools should be expanded beyond the summer to include before and after school programs too. Further, recreation progams should be structured and contain as major goals the building of life skills.

IV. Detention After Arrest/Temporary Emergency Shelters

While the idea of "other than jail" detention is excellent, the possibility for implementation under current conditions is slim to none. A mental health needs assessment of children which we currently are conducting in a 5 state area of the Southwest indicates that there is an absolute crisis in out of home placement resources in Indian communities. Often there is not shelter even for those in need of protective custody due to severe abuse and neglect. Rarely are children in need of temporary shelter over the age of 6 ever placed because of availability constraints.

Any attempts to releave this crisis through payment to private individuals should also include budget items to provide training for "foster families" and some means to monitor these families and the care they are providing.

V. Training Needs Assessment

Included in the assessment should be not only the numbers of children in need of services but the kinds of treatment required, the appropriate settings for same, the duration of various treatment structured aftercare and the implied and companion treatment needs of the families of dependent children.

VI. Comprehensive Alcohol and Drug Abuse Treatment

Treatment programs should be designed to meet the specific needs of adolescents. They should not be an adaptation or extension of adult services. There must be a continuum of care available which includes but is not limited to early identification, structured intervention, out-patient, limited in-patient (45 days), extended in-patient (24 to 36 months), aftercare, co-dependency as a primary diagnosis and intensive family therapy.

VII. Training

The training mandated in the bill for CHR's, school, clinic, law enforcement and shelter personnel is essential. There must be some provision made however, to describe which people should receive training for what aspects of alcohol and drug abuse. For instance:

a) All people involved directly with students should be skilled in identification of drug and alcohol problems and referral procedures;

b) Someone in each of those settings should be skilled in crisis intervention, structured interventions, alcohol and drug assessments, treatment planning, and treatment network development~~s~~; and

c) Someone else should be skilled in developing effective, comprehensive prevention programs.

Further, parent education classes for all people who have students enrolled in federally funded day care and head start programs should be required for a minimum of 40 hours a year. These classes should be aimed at developing parenting skills.

Additional Comments and Recommendations

The average cost in this nation to treat a chemically dependent young person is between $12-20 thousand for a limited in-patient program and the success rate of available treatment hovers around the 30 percent mark. Therefore, we believe it behoves the Congress to consider the addition to the bill of some strong prevention components.

Please consider the following:

1. That planning and implementation of strategies for the prevention of alcoholism be built around community and tribal entities.

2. That strengthening of existing community development programs or creation of new ones require as part of their priorities, strategies to prevent alcohol and drug abuse.

3. That a cost benefit analysis be made and used in each community to emphasize the added benefits of alcoholism prevention.

4. That the highest priority be given to the building of a comprehensive prevention strategy stressing the community leadership's involvement in changing behavior patterns and the development of alternative life styles.

5. That representative Indian organizations under alcoholism contracts or grants be held accountable for actions and funds to their constituency and funding agency.

6. That a formal policy be issued clarifying and affirming the federal responsibility and facilitating the implementation of the act which provides for health services to Indian people wherever they reside.

7. That specific authorities and funds that could make H.R. 1156 an effective reality be contained in the bill. Thus, there is the need to develop the criteria and provide the authorities and appropriations necessary to make this comprehensive approach a program of national scope. This program should be included within a comprehensive health model system.

8. That all entities mentioned in the bill including IHS, BIA and their contractors (tribal and non-tribal) be required to develop and implement a drug and alcohol policy for their employees and a functional employee assistance program within one year.

Any form of alcoholism prevention will have to do more than educate whether this education comes in the form of information or formal training. Patterns of living and attitudes will have to be altered in order to ultimately reduce the incidence of addictions. The community can and should bring pressure on the individuals who live in it. This is what intervention is. But in order for the community to do that, it must feel the pressure upon itself as well. This is what community intervention is. This must be done because neither the community nor its people can ignore these ills anymore or expect the existing alcoholism programs to clear the streets, bars and jails, picking up the end stage and often physically, emotionally and socially half dead people, detox them and bring them back to be healthy, stable and socially conscious and productive beings. Neither morally nor socially can Anglo America and its representatives or Congress afford the continuing failure of crisis oriented programs.

STATEMENT
OF THE
SANTA FE INDIAN SCHOOL

Presented by

Mr. Joseph Abeyta
Superintendent

Honorable Congressman Richardson and committee members, my name is Joseph Abeyta. I am Superintendent of the Santa Fe Indian School, a tribally operated contract school for approximately 500 students in grades seven through twelve. I come before you today to present testimony on H.R. 1156 which addresses substance abuse prevention and coordination of resources to prevent this disease which is ravishing our Indian people, especially our youth, who are our promise for tomorrow.

INTRODUCTION

The All Indian Pueblo Council, representing the Pueblo people of New Mexico, was the first Indian group to gain control of the planning and operation of an educational system under the provisions of P.L. 93-638, the Indian Self-Determination Act (1975). We are proud to say that Santa Fe Indian School is beginning its ninth year of successful operation.

As Indian educators and parents, we wanted to believe that our Indian youth did not have substance abuse problems. But when we contracted for a year of planning at the school in 1976, it was readily apparent that while under the Bureau the school had deteriorated into a warehouse for teenagers where alcohol and other drugs were readily available. Our children did indeed have serious problems which needed our full attention.

After eight years, our official position of the Santa Fe Indian School is that we have met success in terms of curriculum, teacher certification, dormitory environment, etc. but not correspondingly in all areas of substance abuse prevention. We need total awareness and total commitment of everyone who comes in contact with the student to reach a solution to this problem. This solution, as we see it, must take into account that:

1. The student must learn to be responsible for his/her own behavior.
2. The student must be held accountable for his/her behavior.
3. The student must be provided with viable alternatives to substance abuse.
4. The student must be able to explore underlying problems and find workable solutions.

One can reach a solution to this problem through prevention, support groups, and education. However, we cannot and must not make students more dependent and above all we must provide consistency. The student must develop an inner strength to make the right decision.

As all of us know, substance abuse is a complex problem, which is different for each individual, ethnic group, and level of social/economic status. We must now look carefully at what works and what does not work.

I do know at our school we have people who care and are concerned. I would like to recommend that we, as educators and professionals, compile a comprehensive assessment of what is happening in the field. We need to try out our hunches tempered by data that is available from our people in the field. Too often studies of Blacks in Harlem, Anglos in Phoenix, or Chinese-Americans in San Francisco have been the source for substance abuse programs for Native Americans. Each group is different and each group will possibly find new solutions to a serious problem. A program of prevention must be a program of research and education.

With this background as our position, I would now like to specifically address issues proposed by the Bill H.R. 1156.

Source - H.R. 1156: A bill to coordinate and expand services for the prevention, identification, treatment, and follow-up case of alcohol and drug abuse among Indian youth, and for other purposes.

I. Page 4 (3) Lines 12-14

"The training of counselors at schools eligible for funding under this title in counseling techniques relevant to alcohol and drug abuse".

Response:

Training for counselors is essential since it is an area in which many are lacking expertise. However, we recommend that the training should be opened to all staff involved in the school setting, such as teachers, dorm staff and secretaries to make them all aware of the seriousness of the problem and provide them with the tools they need to help the students deal with it. This will increase their ability to better understand, support and provide services in both the intervention and treatment process, especially since at Santa Fe Indian School they are all involved with students.

II. Page 4 (e)

"10 percent of the fellowship awarded under subsection (a) shall be awarded to persons who are receiving training in guidance counseling with a speciality in the area of alcohol and drug abuse counseling and education."

Response:

The 10% should be doubled which would also enable people to obtain more extensive training in this field, especially since they will be the people who not only provide direct services to Indian youth, but assume leadership roles in the implementation of school-wide counseling programs.

III. Section 204 (a) - Page 5, Lines 7-12

"The Secretary of the Interior shall require Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination and Education Act (Public Law 93-638) to provide a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve."

Response:

There is definitely a need to address these problems with today's youth. Schools should address these issues but they should also be allowed to develop their own curriculum and be able to offer it by any means they wish. Once the curriculum is established,participation should be mandatory for all students in all schools.

IV. Section 204 (b) - Page 5, fines 13-15

"Schools providing programs of instruction under subsection (a) are encouraged to emphasize family participation in such instruction."

Response:

This is essential in implementing a successful program whether dealing with intervention or treatment.

V. Section 205 (a)(1) - Page 5, Lines 17-18

"Establish summer recreation and counseling programs for Indian youth on reservations."

Response:

Good community summer programs are essential. They will help to reinforce what was presented at school during the school year,along with providing alternatives. Adequate funding for these programs is essential.

VI. Section 205 (a)(2) - Page 5, Lines 19-24

"Require such Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination Act as he determines to be necessary to remain open during the months of June, July, and August of each year to provide adequate facilities for such programs. .

Response:

The concept of facilities use is good but certain matters need to be addressed, such as, will the use of the facilities interfere with the summer refurbishing of the school facilities? Also will sufficient monies be provided for staffing the facilities being used?

VII. Page 6 (c), Lines 12-14

> "The Secretary of the Interior shall coordinate any programs established under subsection (a)(1) with any other summer programs for Indian youth."

Response:

The coordination of programs should be left up to each program coordinator to determine if other programs will be beneficial to their clientele. Also it should be left up to the Coordinator's to choose the best programs and not just the nearest.

VIII. Section 206 - Page 6 Lines 15-24 - Page 7 Lines 1-2

> "The Secretary of Interior shall, within 20 days of the date of the enactment of this title, publish an alcohol and drug abuse newsletter....".

Response

A newsletter would be highly beneficial to all programs involved in that it will inform everyone as to what's happening in other programs and what's available in the area. The newsletter should include information from all programs involved in treatment and prevention.

IX. Section 301 (a) - Page 7

> "Any training program for community health representatives funded under the act of November 2, 1921 (24 U.S.C. 13) shall include not less then two weeks of training of the problems of alcohol and drug abuse and shall include instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome."

Response:

Training requirements should be increased to more than just two weeks. Training should be ongoing with periodic indepth sessions.

X. Page 8 (g)

"Personnel of school operated under contract under the Indian Self-Determination and Education Act..... Page 7 (b)(1), Line 10-14."

Response:

Agreed; however, the training should not just be offered but required.

XI. Page 9 (c) Lines 15-19

"The Secretary of Health and Human Services shall, upon request, provide certification to any person who completes training under this title for the purpose of obtaining academic credit or certification at any post-secondary educational institution."

Response:

Agreed, this is a good idea.

XII. Page 11 (c)(1), Lines 7-12

(c)(1) "The Director of the Bureau of Indian Affairs shall establish a program and approve a compensation schedule under which households of Indian families will be compensated to serve as temporary emergency shelters for Indian juveniles apprehended by any law enforcement officer for offenses related to the abuse of alcohol or drugs."

Response:

Before households are allowed to act as temporary shelters, the members of those households should be trained. Also some sort of screening system should be devised to determine which children are to be allowed to stay at the shelters. Children who are suicidal or experiencing other major psychological problems would probably not be well served by this system. It could also be highly dangerous to the household involved. Cases of child abuse have also been documented in some unscreened/untrained households.

In conclusion I would like to thank the committee for giving me the opportunity to present this testimony and to express our appreciation for the interest you have taken in our Indian youth.

[illegible]

JOHANNA CLEVENGER M.D.
[illegible]

TESTIMONY TO THE COMMITTEES ON INTERIOR AND INSULAR AFFAIRS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR

CONGRESSIONAL H. R. 1156

Alcoholism is a medical illness.

The Council of Navajo Physicians urges medical participation, particularly psychiatric participation, in alcoholism programs designed for American Indian and Alaskan Native young people. In seeing alcohol and drug abuse and dependency in a more holistic manner much important information is lost if medical input is excluded.

Alcoholism is an illness that exists among individuals who can also be affected by other emotional and psychiatric problems. In my opinion, unless the whole individual and the entire clinical picture is considered there is little hope of having an impact on the alcoholism part of that individual.

Good clinical care and research can be synergistic. Research adds to our understanding of what we do as medical clinicians. In the past, an important research project, the Model Dormitory Project, carried out by Robert L. Bergman, M. D. and his team of mental health professionals demonstrated that increasing the personnel caring for Navajo children who attended a boarding school at Toyei, Arizona, and increasing the clinical understanding of child development of these dormitory personnel had a definite impact on the growth and performance of these children. I think this benefit would be long-standing and meet the challenge of the adolescent turmoil these youngsters would later face. A process of addressing alcohol and drug problems by offering better care for children six to 12 years of age can be implemented at known cost because of the creative approach Doctor Bergman and his colleagues took. Further, by researching such a current project, along the same clinical design, we would gain valuable information about the natural history of alcohol and drug abuse in our young people.

Johanna Clevenger M.D.

JOHANNA CLEVENGER, M.D.
Past President
Association of American Indian Physicians

Charter Member
Council of Navajo Physicians

SOUTHERN UTE INDIAN TRIBAL COUNCIL

PREPARED STATEMENT OF JOHN B. BAKER

SUPPORT OF HR 1156
Albuquerque, New Mexico
June 14, 1985

To Whom It May Concern:

Statement of Support of HR 1156, Indian Juvenile Alcohol and Drug Abuse Prevention Act

The Southern Ute Indian Tribal Council fully supports the objectives of the proposed Indian Juvenile Alcohol and Drug Abuse Prevention Act (HR 1156). In its present form, the proposed legislation represents a positive, constructive approach toward solving a long-standing problem that has become almost pervasive among many tribal groups of Native Americans. Accordingly, our Tribal Council is prepared to make available personnel and physical resources of the Southern Ute Indian Tribe, in collaboration with the Federal Government and its designated agencies and organizations, to help establish a comprehensive program that will bring under lasting control the deleterious abuses of alcohol and illicit drugs among our own and other Indian tribes.

Specifically, the Southern Ute Indian Tribal Council recommends the following:

(1) That the provisions of Sections 204(a) and 204(b) of the proposed Act, which pertain to Bureau of Indian Affairs schools and schools operated under contract pursuant to the Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638), as amended, be extended to provide for such "instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve" also in public schools now receiving funds under the Johnson-O'Malley Act of April 16, 1934, as amended (25 U.S.C.S. §452). The intent of the Johnson-O'Malley Act was to enhance education, promote social welfare and provide relief of distress among Indians. Instruction in the harmful effects of alcohol and drug abuse, through carefully structured educational programs in the public schools with significant Indian student populations, would be entirely in consonance with the stated goals of the Johnson-O'Malley Act.

(2) That the alcohol and drug abuse newsletter provided for under Section 206 of the proposed Act include specific guidelines on establishing the educational programs envisaged, with references to the pertinent parts of the Code of Federal Regulations and related directives, and that sufficient copies of the newsletter be made available for distribution to all affected components of each tribal organization as well as to the public non-tribal agencies having collaborative roles in the program.

(3) That a clearly delineated source of funding, on a continuing basis, be provided for the training programs alluded to under Title III, Family and Social Services, of the proposed Act.

(4) That alcohol and drug abuse treatment facilities, including emergency shelters for Indian juveniles, referred to under Title IV, Law Enforcement, of the proposed Act be federally funded and adequately staffed with professionally trained personnel.

(5) That specific guidelines for the preparation of the study directed under Title V, Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation, be provided promptly to the participating tribal councils by the Director of the Indian Health Service.

(6) That the alcohol and drug abuse treatment programs be available for all tribal members and not just juveniles.

In the opinion of the Southern Ute Indian Tribal Council, the sum of $5,000,000 specified in Section 603(a) is an unduly modest sum in relation to the number of tribal groups expected to participate. Nevertheless, if Section 603(b) is liberally interpreted by the U. S. Congress and the Presidential Administration, the procedural mechanisms for fulfilling the goals of the proposed Act are not beyond the scope of practical achievement.

Respectfully submitted,

Chris A. Baker, Chairman
Southern Ute Indian Tribal Council

CAB:sls

STATEMENT OF MR. VINCENT LITTLE, AREA DIRECTOR, ALBUQUERQUE AREA OFFICE, BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE HEARING OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS, HOUSE OF REPRESENTATIVES, ON H. R. 1156, THE "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT", IN ALBUQUERQUE, NEW MEXICO, JUNE 14, 1985.

Good afternoon. My name is Vincent Little, I am the Albquerque Area Director for the Bureau of Indian Affairs. I would like to introduce Mr. Charles Johnson, the Agency Superintendent for Education at the Ft. Defiance Agency. He will assist me in answering any questions you may have regarding the BIA's education program. We are happy to be here today to talk about the very serious problems of Indian juvenile alcohol and drug abuse.

We consider alcohol and drug abuse to be the most serious social and health problem facing Indian people today. Our statistics show that approximately 85% of BIA and tribal arrests in the Albuquerque Area involve alcohol or drug abuse. In 1982 and 1983 there were over 16,000 arrests of which approximately 12,000 were alcohol or drug abuse related. In 1982 16% of these total arrests were juveniles. In 1983 14% were juveniles. Unfortunately, we do not know how many of the juvenile arrests were alcohol and drug related.

A juvenile is taken into custody under four conditions (1) a court order, (2) if in immediate danger due to abuse or neglect, (3) if there are no parents or guardians, or (4) when a juvenile has committed a crime. Officers are required to notify the juvenile's parents or guardians as soon as possible after the juvenile is taken into custody. The court designated agent or Social Services Agency is promptly notified in neglect and abuse cases. If juveniles are incarcerated in detention facilities, they are required to be detained in a separate room or cell from adults and adequate supervision is to be provided 24 hours a day.

We do not have facilities at all our jails to provide seperate holding cells for adults and juveniles. When such facilities are not available officers transport juveniles to the nearest juvenile holding facility which is generally operated by the State. These arrangements are made through agreements between district and tribal court judges which provide for billing and reimbursements on a daily service basis.

The Bureau of Indian Affairs (BIA) does not have any facilities specially designed for the treatment of alcohol and drug abuse problems. We do however, work with Indian Health Service (IHS) and the tribes when possible to coordinate services.

For example, the IHS provides immunizations for childhood diseases and maintains a nursing station either part or full-time at most Bureau schools. Where nursing facilities are not available, the school personnel provide transportation for the student to the nearest IHS facility. Naturally, the teachers have the best opportunity to recognize health related problems in our students and frequently refer students either formally or informally to IHS for medical services ranging from eye examination to psychological testing. Referral procedures are worked out with the appropriate IHS facility.

The Albuquerque Area has 13 schools and one dormitory serving approximately 2,840 students. Each school is required to provide health education as part of its curriculum and must include alcohol and drug prevention as part of that curriculum. Since the development of the program is a local school decision. The programs of course, vary significantly. Frequently, programs are developed in coordination with the local IHS representative and the tribe and may be as simple as including a unit on the subject as part of the health curriculum, or as extensive as having speakers and special materials in each classroom throughout the year.

An example of one of our more extensive programs can be found at the Santa Fe Indian School which is a contract boarding school for grades 7 through 12. Two full-time counselors are available to the students at all times. Individual counseling and peer group counseling are provided as well as prevention information and evening programs designed to keep students involved in constructive activities. The program, although primarily known for its successful intervention techniques recognizes the potential abuser as well as the student who may be "hooked".

Also, during the month of June both the Institute of American Indian Arts and the Southwestern Indian Polytechnic Institute are hosting workshops on alcoholism. These workshops are designed to provide training specifically for alcoholism counselors and school counselors.

This concludes my prepared statement, we will be happy to answer any questions the Committee may have.

PREPARED STATEMENT OF JOHN B. BUCKANAGA

Mr. Chairman and members of the Committee:

My name is John B. Buckanaga, Area Director of the Albuquerque Area Indian Health Service (IHS). I am accompanied by Ms. Ina Palmer who is the Principal Consultant for Alcoholism for the Albuquerque Area IHS. I am very pleased to be here today to discuss a problem with which the Albuquerque Area is extremely concerned--the serious and growing problem of alcohol abuse by Indian juveniles.

It is evident when we look at the available data that Indian youth represent an understudied and underreported population which warrants much more attention and study. We suspect that the Indian youth in our Area are beginning to use alcohol as early as ages 10-13. Data collected by the Area tribal contracted programs indicate that adults who are in treatment reported beginning to use alcohol at this early age.

Other supported data that indicates alcohol abuse by Indian youth is reported by the Albuquerque Area mental health program in their FY 1984 mental health data. The data show that a large portion of the mental health workload is due to alcohol related problems and stresses undergone by families and youth. More than one-third of patients seen were under age 25 (combined Mental Health/Social Service data).

For age 19 and below in FY 1984 our data showed that 53 youths were treated for alcohol related problems.

TABLE I

Contract Health FY 1984

Diagnosis	Number Patients	Cost
Drug Dependence	1	$ 299.06
DT's	2	1,126.00
Pathologic Alcohol Intoxicate	1	180.00
Acute Alcohol Intoxication	1	959.45
Alcohol Dependence	3	1,361.74
Alcohol Abuse Unspecified	1	461.62
TOTAL	9	$4,406.45

TABLE II

Direct Inpatient - IHS
FY 1984

Diagnosis	Number Patients
Acute Alcohol Intoxication Unspecified	3
Alcohol Abuse	2
Alcohol Dependence Syndrome	4
Non-Dependent Alcohol Abuse	1
TOTAL	10

TABLE III

Ambulatory Clinic IHS
FY 1984

Diagnosis	Number Patients
Alcohol Acute/Chronic	22
Drug Dependence or Abuse	12
TOTAL	34

It is important to explain that the problem appears chronic with a drinking history of heavy alcohol use of periods of 10 years or more, i.e. alcohol dependence and DT's. It is also interesting to note that our statistics show a high incidence of death from cirrhosis of the liver in the group of 15-54 years. Those dying of cirrhosis of the liver had to have started drinking pathologically at least 15 years prior to death. It is also interesting to note that Indian women are dying at a higher rate than Indian men in this age group (see tables IV & V).

The primary health delivery system for alcohol and drug services in the Albuquerque Area is through the contracting mechanism with Tribes and Tribal groups. Our FY 1985 budget for alcoholism contracts is approximately $1.6 million.

TABLE IV

Death by Cirrhosis, Male & Female
Albuquerque Indians, 1972-76
Indian Vital Statistics, 1977

Age	Male	Female
15-34	8.1	11.2
35-54	18.2	20.5

TABLE V

Death by Alcoholism, Male & Female
Albuquerue Area Indians, 1972-76

Age	Male	Female
15-34	6.9	10.1
35-54	16.6	16.2

The significance of Tables IV and V show that females who drink are at a greater risk than males who drink to develop pathology. Studies show that males at a young age consume more alcohol with greater frequency than young females. It is speculated by researchers that young females who drink develop pathology at a greater rate than males. Studies have also shown that females who drink develop organic brain disease at a faster rate than males. These facts are significant in developing prevention activities. Young females even though they drink less at a lesser frequency may need alcohol prevention more than males.

Table VI summarizes the funding levels for the alcohol programs in our area. Of these programs, two programs: the Inter-Tribal Program in Denver, Colorado, and Southwestern Indian Polytechnic Institute Alcohol Education Program are earmarked specifically for youth treatment and prevention. An estimate for the number of youth treated in these two programs is about 150 youths per year. The total number of dollars for these two projects is $251,048.

TABLE VI

ALCOHOLISM PROGRAM BUDGET
Effective March 1, 1985

	1985 Base
Acoma	$ 71,367
AIPC	186,667
Eagle Lodge	174,956
Eight Northern	140,973
Five Sandoval	101,176
Inter-Tribal	164,019
Jicarilla	92,878
Laguna	101,676
Mescalero	109,511
San Felipe	20,799
Santo Domingo	56,307
SIPI	87,029
Southern Ute	274,647
Ute Mountain	67,583
Zuni	92,493
Total NIAAA	$1,742,077
EQUITY FUNDS	
Ramah	13,507
Santa Fe	13,507
	27,014
Subtotal	$1,769,091
Research *	65,000
Other	8,909
TOTAL BUDGET	$1,843,000

*Laguna Youth Alcohol Related Dropout Rate Study.

The referral procedure for either medical care by IHS or contract care for alcoholism treatment is done at the community/service unit level. Currently, the contract tribal programs have letters of agreement or affiliation agreements with their respective Service Unit for medical care and referral for alcohol treatment. Several of our Service Units, e.g., Zuni and Mescalero, have an excellent working relationship with the tribal alcoholism program. The alcoholism counselors make rounds with physicians on the inpatients wards. The counselors are responsible to provide motivated counseling to patients who are admitted for alcohol related illness and accidents. The IHS Service Unit staff participated with the alcoholism program in providing service for alcoholism clients.

Two of our Service Units (Zuni and Santa Fe) have full-time IHS alcoholism counselors in their Service Units to provide inpatient counseling, health education on discharge from the hospital, and referrals to community programs for alcoholism treatment. All of our Service Units have a liaison person who works with their community alcoholism program to provide referrals, technical assistance, training, and direct patient care.

The Service Units all have a letter of agreement to provide medical care, and physicals for clients of community alcoholism programs when necessary, e.g., antabuse therapy and when a client is admitted to an inpatient treatment program.

The responsibility for interaction with the BIA, tribal and other law enforcement agencies is at the community level. The tribal alcoholism programs work with the law offices under a negotiated written agreement. Over 50 percent of the referrals to alcohol treatment are made by the community law enforcement agencies and tribal courts. The community programs also have written agreements and work very closely with the probation departments for referrals.

In the Albuquerque Area, we have, since 1979, greatly increased our emphasis in the area of prevention of alcoholism. We are presently preparing a five-year plan of action to implement prevention activities. Alcoholism prevention is our highest priority. The Albuquerque Area Alcoholism Coordinator is presently conducting a National Prevention Inventory of on-going activities for FY 84 and FY 85. A plan of action for prevention will be developed for the Area after completion of this survey in July 1985.

Presently, the programs as shown in Table VI are using at least 10 percent of their resources in primary prevention and intervention activities in their community. Some of their activities include working in the schools with families and youth groups. Many of their activities are directed toward promoting healthy life styles and alcohol education.

Thank you for the opportunity to share our concerns with you today on juvenile alcoholism in the Albuquerque Area.

I will be happy to try to answer any questions you may have.

PREPARED STATEMENT OF MICHAEL E. LINCOLN

Testimony on HR 1156

Mr. Chairman, members of the Committee, my name is Michel E. Lincoln and I am Director of the Navajo Area Indian Health Service, located in Window Rock, Arizona. I thank you for the opportunity to speak about House Resolution 1156, entitled the "Indian Juvenile Alcohol and Drug Abuse Prevention Act".

I will provide some health data and, if time permits, answer questions from the committee. Some questions will also be answered by the Navajo Tribal Alcoholism Program's testimony today.

I have reviewed the proposed legislation of Mister Bereuter, and his colleagues along with similar proposed legislation by Mr. McCain. The Congressmen are to be commended for their interest and efforts regarding this health issue. I am impressed with the breadth of involvement that both bills propose. Their emphasis on wide involvement is similar to the practice of many tribes to include as many members as possible in decision-making and community planning. An emphasis on cooperation rather than competitiveness serves to share power and strengthen community concern and involvement.

The Navajo Area Indian Health Service provides direct health care to adolescents with alcohol or drug problems and it also supports the Navajo Tribe in its alcohol prevention and treatment efforts. Financially, Navajo Area is contributing a total of $2,049,000 in F.Y. 1985. This is administered in two grants; the first is $1,813,000 to the Navajo Alcoholism Program (NAP) and the second is $236,000 to the KASHWIN demonstration projection. The latter money comes from health care equity dollars. It is to be used in underfunded parts of the reservation--namely, Kayenta, Shiprock, and Winslow. A part of this demonstration project, which was set up recently, is to focus on prevention efforts to reduce teen-age alcohol and drug abuse, e.g., through education and peer counseling.

While the overall problem of alcohol and drug abuse is very serious, there are accomplishments being made by IHS and the Navajo Tribe. Some objectives to reduce rates of accidents and/or alcoholism are being met and rates are falling. Table One shows four objectives that are of particular concern to the NAIHS. They come from the Navajo Nation Master Health Plan. Whether through better education, improved safety awareness, better law enforcement, or improved health care--or a combination of the four--progress is being made.

In the first objective cited, the greatest proportion of all accidents occurred among ages 25-44 (26 percent). Likewise, in the fourth objective, the greatest number of reported visits by alcoholic patients were among the 25-44 age group (71.4 percent). By targeting youth for substance abuse prevention and treatment, we can head off the cumulative effect of problems that will manifest themselves in adulthood.

Incident reports can show increases and decreases. Unfortunately, our current data collection efforts cannot show outcome of individual treatment. This problem is being addressed as we improve our system with automated data processing equipment and patient record-oriented data collection.

Currently, IHS social service and mental health data shows number of patients and number of patient contacts. Table Two shows FY 1984 quarterly activity for the two Branches combined. It is presented in this format to put an emphasis on what was the treatment of alcohol and drug abuse. A look at the two programs separately would reveal that mental health, with a larger staff than social services, has more contacts.

The number of patients and/or their families seen with alcohol related problems averaged 11.5 percent of the combined workload. When number of patient contacts was examined, it averaged 6.6 percent of the workload. Two possible explanations exist for "fewer contacts" in alcohol and drug abuse. One is that there are fewer average contacts involved in the referral of these patients to specific alcohol or drug treatment programs. Two is that the patients were seen more often, but under other problem categories, related to alcohol and drug abuse, e.g., "anxiety" related to the withdrawal process or "depressed" related to problems underneath the addiction. The percentages refer to narrow categories that do not cover the entire involvement of social services and mental health. A lot of child abuse and spouse abuse, family conflicts, unemployment cases seen are related to the problem of alcoholism and drug abuse.

As I present these figures and the qualifications that accompany them, I am interested in the proposed legislation's plans for determining the scope of the Indian juvenile alcohol and drug problems. This is necessary, since the several agencies involved have a partial picture of their part of the problem. Better overall data would aid all of us in program planning.

In closing, I would like to say that this proposed legislation calls for broad involvement in treating the problem of adolescent alcohol and drug abuse. This is compatible with Navajo approaches to problem solving and should be encouraged.

ATTACHMENT A:

Mr. Chairman, members of the Committee, my name is Michel E. Lincoln and I am Director of the Navajo Area Indian Health Service, located in Window Rock, Arizona. I thank you for the opportunity to testify about juvenile alcohol and drug abuse in the Navajo Area.

I understand that other representatives of the Department will have the opportunity to testify on H.R. 1156, the bill under consideration, at a later date.

The Navajo Area Indian Health Service provides direct health care to adolescents with alcohol or drug problems and it also supports the Navajo Tribe in its alcohol prevention and treatment efforts. The Navajo Area is contributing a total of $2,049,000 in F.Y. 1985. This is administered in two grants; the first is $1,813,000 to the Navajo Alcoholism Program (NAP); and the second is $236,000 to the KASHWIN demonstration projection. The latter money comes from health care equity dollars, and it is to be used in underfunded parts of the reservation—namely, Kayenta, Shiprock, and Winslow. A part of this demonstration project, which was set up recently, is to focus on prevention efforts to reduce teen-age alcohol and drug abuse, e.g., through education and peer counseling.

While work remains on the serious, overall problem of alcohol and drug abuse, there are accomplishments being made by IHS and the Navajo Tribe. Some objectives to reduce rates of accidents and/or alcoholism are being met and rates are falling. Table One shows four objectives that are of particular concern to the NAIHS. They come from the Navajo Nation Master Health Plan. Whether through better education, improved safety awareness, better law enforcement, or improved health care—or a combination of the four—progress is being made.

In the first objective cited, the greatest proportion of all accidents occurred among ages 25-44 (28 percent). Likewise, in the fourth objective, the greatest number of reported visits by alcoholic patients were among the 25-44 age group (71.4 percent). By targeting youth for substance abuse prevention and treatment, we can head off the cumulative effect of problems that will manifest themselves in adulthood.

Incident reports can show increases and decreases. Unfortunately, our current data collection efforts cannot show outcome of individual treatment. This problem is being addressed as we improve our system with automated data processing equipment and patient record-oriented data collection.

Currently, IHS social service and mental health data shows number of patients and number of patient contacts. Table Two shows FY 1984 quarterly activity for the two Branches combined. It is presented in this format to put an emphasis on what was the treatment of alcohol and drug abuse. A look at the two programs separately would reveal that mental health, with a larger staff than social services, has more contacts.

The number of patients and/or their families seen with alcohol related problems averaged 11.5 percent of the combined workload. When number of patient contacts was examined, it averaged 8.6 percent of the workload. Two possible explanations exist for "fewer contacts" in alcohol and drug abuse. One is that there are fewer average contacts involved in the referral of these patients to specific alcohol or drug treatment programs. Two is that the patients were seen more often, but under other problem categories, related to alcohol and drug abuse, e.g., "anxiety" related to the withdrawal process or "depressed" related to problems underneath the addiction. The percentages refer to narrow categories that do not cover the entire involvement of social services and mental health. A lot of child abuse and spouse abuse, family conflicts, unemployment cases seen are related to the problem of alcoholism and drug abuse.

This concludes my prepared statement. I will be happy to answer any questions concerning our activities in the Navajo Area on this issue.

TABLE ONE

Comparison of Progress
on Four Health Objectives
Indirectly or Directly Related to Alcoholism

Health Objective	Actual Decrease & Percentage			(Proposed Decrease & Percentage)	
	1976*	1982*	%+	1988*	%+
Reduce incidence of accidents, poisonings, and violence	248.0	157.1	-36.7	(133.5	-15.0)
Reduce incidence of motor vehicle accidents	20.0	12.6	-37.0	(8.8	-30.0)
Reduce incidence of alcohol-related accidents, poisonings, and violence	26.9	23.8	-11.5	(21.4	-10.0)
Reduce incidence of acute and chronic alcoholism	12.1	7.9	-34.7	(7.1	-10.0)

*Based on a rate per 1,000 population.

SOURCE OF DATA: Navajo Nation Master Health Plan, Health Status Chapter, March 1985.

TABLE TWO

Number of Patients and Number of Patient Contacts, Regarding Alcohol and Drug Problems in Relation to the Overall Social Services and Mental Health Workload

F.Y. 1984	Number of Patients with Alcohol or Drug Problems in Relation to Overall Patients Seen and Percentages		Number of Patient Contacts, Regarding Alcohol or Drug Problems in Relation to Overall Workload and Percentages	
1st Quarter	224/2023	(11.1)	392/4890	(8.0)
2nd Quarter	240/2144	(11.2)	511/5529	(9.2)
3rd Quarter	235/2130	(11.0)	447/5147	(8.7)
4th Quarter	283/2232	(12.7)	594/7042	(8.4)
TOTAL	982/8529*	(11.5)	1944/22,608	

*Unduplicated patient counts for each quarter, but adding together may get some duplication of patients seen in more than one quarter; therefore, these totals are qualified.

SOURCE OF DATA: Social and Mental Health Services Reports, NAIHS

Amethyst Hall Corporation

June 28, 1985

House Committee on Interior and
Insular Affairs
1324 Longworth House Office Building
Washington, D.C. 20515

SUBJECT: Testimony on House Bill 1156 -- Indian Juvenile Alcohol and Drug Abuse Prevention Act

Dear Members of the Committee:

I attended the hearing which was held by your Committee at Albuquerque, New Mexico on June 14, 1985, regarding House Bill 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act. Based upon that hearing and a review of the proposed legislation, I feel it is appropriate to provide you with some insights from the private treatment community regarding the treatment of substance abuse among Native American adolescents. I have reviewed the proposed legislation and discussed it with my colleagues. Basically, we are very pleased to see Congress addressing the enormous problem which chemical dependency presents in the lives of Native American adolescents. We would recommend, however, that the legislation be clarified in certain aspects to assure the best utilization of the public and private treatment resources available to work with Native Americans who are dependent on alcohol or other chemicals.

To introduce myself, I am a field representative for the Amethyst Hall recovery center, a private, for-profit chemical dependency treatment center located in Velarde, New Mexico, north of Santa Fe. The area I service includes Gallup, New Mexico and the Navajo Reservation, as well as other southwestern areas adjacent to or serving reservation populations. My work involves making individuals and referral agencies familiar with the Amethyst Hall program, receiving patient referrals, and arranging for treatment at Amethyst Hall of those referred. In this capacity, I have had extensive dealings with the Indian Health Service, tribal alcoholism programs, local community service and referral agencies, private physicians making referrals, and of course, Native American adults and juveniles suffering from chemical dependency. The program at Amethyst Hall, to which I refer patients includes both an adult program and an adolescent program. Amethyst Hall is a free-standing treatment program, that is, not associated with a Hospital or medical facility. In the past year I have been involved in the referral of many Navajo adults and adolescents to the Amethyst Hall program and have followed up on many of them on their return to their home community.

In obtaining services for potential patients, I have had many dealings with the Indian Health Service. In fact, the IHS in this area has referred

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several adult and adolescent patients on a contracted basis. Through these experiences, and in following up on patients I have referred and potential patients I have interviewed, I have had the opportunity to learn a great deal about the existing treatment opportunities for Native American adolescents and the need for more treatment opportunities. It is based upon these experiences that I offer these recommendations regarding H.R. 1156.

I also comment based upon my personal experiences. I am an enrolled member of the Navajo Tribe. I am also a recovering alcoholic. My addiction began at the age of 14 while attending public school in Gallup and residing in a BIA dormitory. In the course of my recovery, I have been involved with the local alcohol treatment and referral program in Gallup, with a state operated treatment facility, and with a private treatment facility where I was finally able to achieve the beginning of long-term sobriety. I have described some of my treatment experience in a letter sent to the National Institute on Alcohol Abuse and Alcoholism in response to a call in the Federal Register for comments on a National Plan to combat alcohol abuse. I am forwarding a copy of that statement to this Committee as well for your information and review, as well as a copy of a review of adolescent substance abuse in the Navajo Nation which was prepared by the Education Committee and the Health and Human Services Committee of the Navajo Tribal Council. I hope you will find this information helpful in your deliberations on this legislation.

Based upon my own experiences in seeking recovery from alcoholism and upon my experiences since going to work for Amethyst Hall, I have developed a real appreciation of what the private sector can contribute to the treatment of chemically dependent Native Americans. Private-sector programs are often more cost effective, both in regard to the actual cost of services per patient and in the effectiveness of the treatment received. Good quality private treatment centers have a high rate of success, often seeing 80% or more of the patients they treat achieving long-term sobriety. This is also a saving, both of money and of lives. Many of the costs of public treatment are hidden within overall departmental budgets, making these programs more costly than initially appears. For example, the public treatment facility where I was first sent for treatment had an official charge of $1500. The actual cost, however, was several thousand dollars more. In addition, the success rate of the program was approximately 30%, meaning that 70% of those served required additional treatment to achieve long-term sobriety. Not all of these, of course, return, as I did, for further treatment. Many decide that their case is truly hopeless and give up, ultimately dying of this disease.

My concern with H.R. 1156 is that it does not address the use of private treatment facilities as part of the overall program for dealing with alcohol and drug abuse among Native American adolescents. I feel that the legislation will be stronger and bring about more of the results hoped for if specific reference is made at several key places in the bill to utilizing available public and private treatment programs and resources. Such specific reference will give more flexibility to the Indian Health Service and its local service unit directors in obtaining the most effective services , in terms both of cost and results, for the patients they serve and refer. In the detailed analysis which follows, I have indicated where such language might be inserted.

In addition, I am concerned that program effectiveness be included in the criteria which must be considered in utilizing any treatment program on ih developing programs. There is a need for more facilities, as the legislation recognizes. However, these facilities must be appropriate to the needs of treatment. They must be therapeutically sound as well as structurally sound. They must not be depressing or convey a feeling of hopelessness to the patients who are referred there. And they must house programs which are effective. It is, unfortunately, possible to throw a great deal of money at the disease of alcoholism and chemical dependency without having any significant impact on it. Fortunately, however, it is also possible to focus efforts and financial resources on existing programs which are effective, to develop new programs based upon models which have proven effective in other treatment centers , and to use the public funding of treatment as a means for obtaining data about both the patients and the treatment they receive which can aid the public and private treatment community in developing even more effective treatment modalities.

One area of treatment which is often given light consideration in publically funded programs is the area of family involvement. This is an area which can be addressed with particular effectiveness by the public sector. It is also, in my experience, one of the most important areas for assisting the chemically dependent person to achieve long-term sobriety after a course of treatment. Families need to be involved from the beginning of the referral process. If possible, families should be included in the treatment process through family weeks. Travel to treatment facilities is not often possible for low income families. In one case, where a number of Navajo adolescents had been referred to the Amethyst Hall program, we brought family week back to the home community, holding sessions at Crownpoint and Gallup. Similar arrangements could be made through coordinating the efforts of the treatment facility and community-based outpatient programs.

Aftercare is also extremely important for the returning patient and for his or her family. This is also an area where community based programs can and should work with the public and private treatment centers. Amethyst Hall provides its own aftercare. One reason for this is the difficulty in obtaining coordination and cooperation from some of the community-based programs. When I went to a public treatment facility, there was no coordinated follow up available from the community based program that had referred me. No records were shared, or program was set up. I was sent home to "find an AA meeting". I did find a meeting, and I believe it saved my life. However, it required additional treatment before I was able to fully benefit from that meeting and achieve lasting sobriety. I am convinced that the lack of continuity between the treatment center program and what followed contributed to my lack of success in this first effort at sobriety.

With these considerations in mind, I have reviewed the language of H.R. 1156 and have some specific recommendations as to where certain of my concerns could be specifically referenced in the bill. I am attaching that analysis to these remarks. I hope that you will give careful consideration to these suggestions. Chemical dependency is a stubborn and frustrating medical and societal problem. It is not an insoluble problem, however. Many adults and adolescents are achieving long-term sobriety through a combination of effective treatment and Alcoholics Anonymous or Narcotics Anonymous. Wise use of public funds and programs can help even more.

Again, I would like to thank you for the opportunity to present these views to the Committee. I am available to discuss further any of the matters referenced by this testimony with any member of the Committee or with Committee staff.

Sincerely,

John H McLean

John H. McLean, Field Representative
Amethyst Hall Recovery Center
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PROPOSED ADDITIONS AND MODIFICATIONS TO H.R. 1156

Title I. Section 101(a)(2). This is a good section. It is important that private resources be identified and utilized as well as public resources.

Title I, Section 101(a). This section should include an additional subsection requiring the Secretary of Health and Human Services and Secretary of Interior to:

> "(7) review and evaluate the effectiveness of existing public and private treatment programs, both for adults and adolescents and review the current knowledge regarding effective treatment modalities for Native American adolescents and adults."

Title I, Section 101(b)(1), page 3, line 2, after "Indian organizations" insert the language:

> "and the therapeutic professionals dealing with the treatment of chemical dependency" .

Title I, Section 102(b)(1), page 3, line 16, after the word "all", insert the words "public and private".

Title II, Section 205(a)(3), page 6, line 1. After the word "salaried" insert the words "and trained"

Title II, Section 206, page 6, line 18, after the word "Education", insert the words "and public and private service providers".

Title III. Language should be developed for this section directing social service agencies and community health representatives, IHS outpatient programs and other community programs to coordinate with public and private providers of inpatient treatment family therapeutic and counselling services and coordinated aftercare services.

Title III, Section 301(b)(2), page 9, after line 14. Insert an additional subsection:

> "(L) personnel of service agencies and organizations providing family counselling, crisis shelter services for families, substance abuse counselling or crisis intervention to significant numbers of Native Americans".

Title IV, Section 402(a)(1), page 10, line 8. After the word "available", insert the following language:

> "or refer the juvenile to an appropriate and available public or private in-patient treatment facility."

Title IV, Section 402(b)(1), page 11, line 4. After the word "available", insert the language:

> "or refer the juvenile to an appropriate and available public or private in-patient treatment facility."

Title V, Section 501 (2), page 12, 19n3 14, after the word "located", insert the words:

> "including both public and private treatment facilities".

Title V, Section 501, page 12, after line 15. Insert a new subsection stating:

> "(4) the effectiveness of various existing public and private treatment programs and the effectiveness of different treatment modalities".

Title V, Section 502(a), page 12, line 21, after the word "Act", insert the language:

> " and services provided under contract by public and private treatment facilities".

Title V, Section 503(a)(1), page 13, line 8. Change the word "possible" to "appropriate".

Title V, Section 503(a)(1), page 13, line 11. Change the "." to ";" and insert the language:

> "however, this section does not justify the establishment of treatment programs in unsound, inadequate or therapeutically inappropriate facilities."

Title V, Section 503(b), page 13, line 25. Change the "." to ";" and insert the language:

> "however, this section does not justify the establishment of treatment programs in unsound, inadequate or therapeutically inappropriate facilities."

Title V, Section 503(b), page 14, line 6. . After the word "needs", insert the language:

> "or to contract for the provision of services in available public or private facilities. Facilities renovated under this title may be operated under contract with public or private service providers as well as directly operated by the Indian Health Service or an Indian tribe."

Title V, Section 503(b), page 14, after line 6. Insert a subsection to provide that the Secretary shall seek the advice of public and private providers of chemical dependency treatment as well as nationally recognized organizations establishing treatment standards in determining the appropriateness of any treatment program operated in a facility renovated or constructed pursuant to this section.

APPENDIX III

SATURDAY, JUNE 15, 1985

Additional Material Submitted for the Hearing Record

HONORABLE JOHN MCCAIN
OF ARIZONA
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
PHOENIX, ARIZONA
JUNE 15, 1985

MR. CHAIRMAN, IN RECENT MONTHS DRUG AND ALCOHOL ABUSE HAS,RIGHTFULLY SO, BEEN HIGHLIGHTED NATIONALLY. THIS IS THE FIRST STEP IN TREATING THE DISEASE--THE RECOGNITION OF THE EXTENT OF ITS EXISTENCE.

TODAY, WE ARE HERE IN PHOENIX TO EXAMINE ONE ASPECT OF THIS NATIONAL PROBLEM-- DRUG AND ALCOHOL ABUSE AMONG OUR INDIAN YOUTH. I BELIEVE THAT THE WITNESSES TODAY WILL PROVIDE THE COMMITTEE WITH THE INFORMATION AND IDEAS NECESSARY TO MOVE LEGISLATION THAT WILL ACTUALLY HELP OUR YOUNG INDIANS.

I WOULD LIKE TO COMMEND CHAIRMAN UDALL FOR SCHEDULING THIS SERIES OF IMPORTANT HEARINGS, AND THANK YOU, MR. RICHARDSON, FOR CHAIRING TODAY'S HEARING.

THE PROBLEMS AMONG OUR AMERICAN NATIVES ARE PERVASIVE WITH HIGH UNEMPLOYMENT, POOR HOUSING, INADEQUATE HEALTH CARE AND THE PERCEPTION OF LITTLE OR NO FUTURE ON THE RESERVATION. UNFORTUNATELY, TOO MANY OF OUR INDIAN YOUTH RESORT TO DRUG AND ALCOHOL ABUSE. I AM NOT JUST TALKING ABOUT THE BEER BLAST OR THE SMOKING OF MARIJUANA--BUT OF EVEN MORE TERRIBLE ABUSE. ON SOME POOR RESERVATIONS WHERE THE "HOLLYWOOD' GLAMOUR DRUGS LIKE COCAINE DO NOT EXIST, SOME INDIAN YOUTH RESORT TO "HUFFING GASOLINE",DRINKING STERNO AND EVEN INHALING HOUSEHOLD ITEMS SUCH AS LYSOL AND HAIR SPRAY.

ACROSS THE NATION, ON AND NEAR RESERVATIONS, EVEN HERE IN ARIZONA, THE PROBLEMS OF DRUG AND ALCOHOL ABUSE SHOULD BE LABELED EPIDEMIC. BECAUSE OF THIS I HAVE INTRODUCED ONE OF THE PIECES OF LEGISLATION BEFORE THE COMMITTEE TODAY (H.R. 2624). BOTH BILLS ARE DIRECTED AT BEGINNING TO ADDRESS THIS PROBLEM THROUGH COOPERATION, EDUCATION AND COUNSELING WITH A GOAL TOWARD PREVENTION.

IT IS A COMPLEX PROBLEM WITHOUT EASY ANSWERS--WE CANNOT JUST APPROPRIATE MONEY AND WISH THE PROBLEM AWAY. HOWEVER, WITH THE COORDINATED DEDICATION OF LOCAL LEADERSHIP, WE CAN BEGIN DOWN THE RIGHT PATH. AND WE MUST NOT FORGET TO CONSIDER THE FAMILIES OF THOSE JUVENILE VICTIMS OF THE DISEASE. A STRONG FAMILY STRUCTURE WILL AID IN THE TREATMENT OF DRUG AND ALCOHOL ABUSE.

IN H.R. 2624, I PROPOSE THAT TO THE GREATEST EXTENT POSSIBLE DRUG AND ALCOHOL ABUSE PROGRAMS BE PLACED IN LOCAL CONTROL. TRIBAL GOVERNMENTS OR ENTITIES WITHIN THE TRIBES KNOW MUCH BETTER THE EXTENT OF THE PROBLEM AND HAVE AN UNDERSTANDING OF THE INTERRELATIONSHIP BETWEEN THE ABUSE AND EXISTING TRIBAL PROBLEMS.

HOWEVER, SINCE THIS IS A NATIONAL PROBLEM WITH OVERLAPPING CAUSES, I ALSO PROPOSE THAT EXISTING AND NEW FEDERAL PROGRAMS BE BETTER COORDINATED AND FOCUSED. I DO NOT WISH TO CREATE A VAST NEW BUREAUCRACY, WHICH EAT UP SCARCE DOLLARS. PROGRAMS EXIST IN THE DEPARTMENTS OF THE INTERIOR, OF EDUCATION, AND ESPECIALLY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITHOUT A COORDINATED EFFORT, DUPLICATION AND CONFLICTING SOLUTIONS CAN NEGATE SOME OF OUR BEST EFFORTS.

I BELIEVE THAT EDUCATION IS AN IMPORTANT ELEMENT TO A PREVENTION PROGRAM. IT MAY NOT BE THE ANSWER TO THOSE ALREADY RACKED BY THE DISEASE BUT IT CAN GO A LONG WAY TOWARD PREVENTING MANY OF OUR YOUTH FROM EXPERIMENTING WITH OR ABUSING DANGEROUS DRUGS, INHALANTS, OR ALCOHOL.

IN ADDITION TO SEARCHING FOR PREVENTIVE SOLUTIONS TO THE ABUSE--THROUGH EDUCATION AND COUNSELING--I RECOGNIZE THAT ON MANY RESERVATIONS A CRISIS HAS DEVELOPED. IN MY LEGISLATION, THE SECRETARY OF HHS WOULD BE DIRECTED TO IDENTIFY THESE CRISIS AREAS, COORDINATE THE MANY PROGRAMS WITH IN HHS, AND CONCENTRATE THE AVAILABLE RESOURCES IN THE CRISIS AREAS TO COMBAT THE DISEASE. I AM NOT TALKING ONLY ABOUT THE RESOURCES OF THE INDIAN HEALTH SERVICE, BUT FROM THROUGHOUT THE HHS. THE EXPERTISE IN THE HHS ABOUT THIS DISEASE IS IN THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION.

IT IS MY HOPE THAT THE EXPERTISE ALREADY EXISTING CAN BE QUICKLY FOCUSED ON THE INDIAN YOUTH DRUG AND ALCOHOL ABUSE PROBLEM. THE KEY TO LONG-TERM SUCCESS IS WITH THE YOUNG PEOPLE OF THIS COUNTRY. DRUG AND ALCOHOL ABUSE AFFECTS ALL OUR NATION'S YOUNG PEOPLE -- WHETHER THEY ARE INDIAN, BLACK, WHITE, POOR OR EVEN ADVANTAGED. WE MUST DO WHAT WE CAN TO DEVELOP THE OPPORTUNITIES OF ALL OUR PEOPLE THROUGH OUR MOST PRECIOUS RESOURCE--OUR YOUNG PEOPLE.

I REALIZE THAT MANY GOOD IDEAS EXIST ABOUT HOW TO ADDRESS THE PROBLEM FROM THE ASPECT OF A FEDERAL RESPONSIBILITY. A FULL EXAMINATION IS NECESSARY OF ALL IDEAS, SO THAT WE, AS LEGISLATORS, ENACT SOMETHING TO ACTUALLY HELP OUR INDIAN YOUTH AND NOT JUST EXPAND BUREAUCRACIES. IT IS MY HOPE THAT A CONSENSUS WILL FORM ON THE BEST SOLUTION TO HELP OUR INDIAN YOUTH.

Statement of Rep. Jim Kolbe to House Interior Committee on HR 2624, Indian Youth Drug and Alcohol Abuse Act

June 15, 1985

Mr. Chairman, today you will be discussing two pieces of legislation that address the serious national problem of drug and alcohol abuse amoung our Indian youth. I believe strongly that we have an obligation to help the youth on our reservations who have fallen into the trap of addiction. Much has been written and said about the tragic problem of alcohol and drug abuse amoung American Indians. But if we are ever going to break this cycle of addiction, despair and poverty, we must begin with the next generation, with young people.

The legislation before you represents a first step in recognizing and solving this problem. We must recognize that many of our Indian youth are discouraged by the lack of opportunity offered by their Reservations and in their frustration turn to substance abuse. The problem is much more extensive and serious than the occasional beer party or a joint of marijuana. I have seen reports that Indian youth on some Reservations have taken to snorting inhalants like gasoline, sterno and everyday household products such as Lysol Spray.

The problem of Indian youth abusing drugs and alcohol is one without easy answers. The solution is not to throw money at the problem and hope it goes away. Only with the help of local involvement can we hope to achieve success. I believe that we will do best to place the drug and alcohol abuse programs in local control. Tribal leaders at the local level are best equipped to find beneficial approaches to the problem and have the best understanding of the interrelationship between the abuse and other reservation and tribal problems.

The approach taken by HR 2624, introduced in the House of Representatives by a legislator I greatly respect, Congressman John McCain, is a good start. HR 2624 directs the Secretary of Health and Human Services to identify Reservations that have a crisis situation and then to coordinate the various programs within HHS to combat the problem. The bill is important in directing the Secretary to utilize not only the existing resources of the Indian Health Service but resources throughout the HHS to help stop this disease. In this way, the Alcohol, Drug Abuse and Mental Health Administration within the HHS will add its weight to the effort by the Indian Health Servive. Moreover, the bill calls for the establishment of an Office of Indian Juvenile Alcohol and Drug Abuse within the HHS Department.

HR 2624 is important because it authorizes an argeement to be made amoung the Departments of HHS, Education and Interior for educational programs from all three agencies to be used in teaching our Indian youth about the hazards of drug abuse. Education is the key to prevention and HR 2624 takes an important step in that direction. The bill calls for training of Reservation teachers and counselors and would require drug abuse programs in BIA schools.

I believe this bill is a good beginning in focusing our existing resources on the abuse problem. We must strive to combat the existing situation and at the same time commit ourselves to prevention through education. HR 2624 is the right approach. I commend Congressman McCain for his efforts in this area and I urge my fellow members to support this legislation.

COLORADO RIVER INDIAN TRIBES
Colorado River Indian Reservation
ROUTE 1, BOX 23 B
TELEPHONE [illegible]
PARKER, ARIZONA [illegible]

TESTIMONY OF

THE COLORADO RIVER INDIAN TRIBES

TO

THE HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
ON HOUSE RESOLUTION 1156

JUNE 15, 1985

PHOENIX, ARIZONA

Mr. Chairman and Members of the Committee:

My name is Franklin McCabe, Jr., I am the Treasurer of the Colorado River Indian Tribes of Parker, Arizona, I have the authorization to present testimony on behalf of the Colorado River Indian Tribes.

Behavioral Health Services represents the primary source of drug and alcohol services for the Colorado River Indian Reservation. Membership is made up of Mohave, Chemehuevi, Navajo and Hopi Indians, with a total enrollment of 2,790. There are 866 Tribal members under the age of 18 living on the Reservation, 412 male and 454 female. The arrest record for Tribal juveniles for the year totaled 122 (substance abuse related offenses). This represents 36.2% of our youth between the ages of 11 to 18.

The prevention of alcohol and drug abuse among Indian youth and the promotion of healthy, productive lifestyles is an important priority of the Colorado River Indian Tribes.

The Tribal government provides coordinated services for Tribal youth which include:

Alcohol and Drug Prevention (Education and Counseling);

After School Tutoring;

Juvenile Probation;

Education Counseling;

Cultural and Recreational Activities;

Summer Youth Employment.

The above stated services are supported by a variety of resources, including:

Tribal revenue funds;

Arizona State Department of Health funds;

Indian Education Act Title IV funds;

Law Enforcement funds;

Johnson-O'Malley funds.

The Tribes support the comprehensive integrated approaches contained in H.R. 1156. These approaches are needed to address the problems of Indian juvenile alcohol and drug abuse. Our Tribal government is now performing many of the activities intended by the legislation; however, there are some issues that need to be addressed in the service delivery system.

The Indian Health Service funded Alcohol and Drug abuse programs are required to utilize the Alcoholism Treatment and Guidance System and require excessive paperwork. A total of fifteen forms must be filled out for the registration of an individual client. This takes valuable time away from counseling activity. Assessment of whether the programs are beneficial, justifies the expense of data collection, and dissemination is needed. We feel that data reporting should be limited to necessary information needed for management monitoring (a one-page form).

There are problems in assessing services, e.g., the formats for program evaluation change yearly and there must be consistency in order to obtain measurable outcomes in treatment and other program service delivery. The role/purpose/function of evaluation and research and the intended use of findings are not clearly communicated.

Since prevention is a long-term project, there is need for stability in funding of such programs. Currently, Alcohol and Drug abuse programs attempt to comply with priorities which tend to change every year by the funding agencies.

Cooperative Agreements have been useful in coordinating efforts and defining roles of more than one agency in addressing a particular problem. We support Section 102 of Title I, of the Interdepartmental Agreement, which provides this at the request of our Tribal government.

Title II - Education: We support those provisions as stated.

Title III - Family Services: The problems that beset all such programs can only be dealt with through improved relationships between trained and experienced specialists and community leaders involvement in the creation and implementation of programs.

Title IV - Law Enforcement: The tribal government has a juvenile code which establishes procedures for handling juveniles arrested for alcohol and drug offenses. The legislation requires shelter placement, which may not be the best option for serious drug trafficking or for one who is violent. We support the recommendation by ITCA, Inc., that the language at 402(a)(1) line 6 be changed to read, ". . . drugs or alcohol shall, when appropriate, detain such juvenile in a temporary emergency center. . ."

Title V - Treatment and Rehabilitation: Residential treatment facilities for youth is a concern when out-of-home care is necessary. We prefer community based treatment facilities as opposed to the regional centers proposed. Success rate is more likely when the youth is involved in the identification of community support systems with which they are familiar. The Tribal and I.H.S. service units could review those existing facilities with low bed utilization in order to determine whether beds can be set aside for Indian juvenile medical detoxification. This would be an alternative since I.H.S. Alcohol and Drug abuse programs are under-funded.

With the Indian Juvenile Alcohol and Drug Abuse Prevention Act focusing on the Indian youth, we are encouraged that we will be able to continue to provide services to our major community resource, the youth.

With these recommendations and comments, we support the H.R. 1156.

Ft. McDowell Mohave-Apache
Indian Community
P.O. Box 17779
Fountain Hills, Arizona 85268

TESTIMONY FOR H.R. 1156

I, Louis Hood, have been requested by the Ft. McDowell Tribal Council to testify on H.R. 1156, Indian Juvenile Alcohol and Drug Prevention Act. Ft. McDowell is a Yavapai community with a population of 398 people and is located 28 miles northeast of Phoenix. Over 1/3 of our population (140) is under the age of 18 years. Therefore, one can see that we stand to benefit greatly by H.R. 1156 if it is passed.

Alcoholism and alcohol-related problems are the number one health and social service prblems facing our community. It impacts our children in their completion of schooling and disruption can be evidenced by the large number of family members seeking assistance from tribal social service and the high number of calls that our community police must respond to in which alcohol and substance abuse are at the foundation. It is for the above concerns that we, the Ft. McDowell people, support the intent of the law. We would also like to say that coordination of prevention services, which is Title I of the Act, implies that there are systems already in existence which are addressing this problem. It is important to note that at Ft. McDowell we have few resources available, and what we really lack is financial resources to develop prevention programs for community juveniles in primary and secondary alcohol and drug abuse. It is unclear in Title I at what point tribes will be involved in developing coordination agreements with IHS and BIA. This needs to be clearly stated. For example, in Section 101, (a) (3) the responsibilities of BIA and IHS in coordinating alcohol and drug abuse need to be outlined, and funds need to be appropriated for this endeavor. No funds have been allocated in this section. How will this work be funded through current budgets?

In Title II - Education, we support the notion that 10 percent of the fellowships under the Indian Education Act be given to people specializing in substance abuse guidance counseling. This would also apply to the Adult Education Act which could be amended to include substance abuse counseling. It is also important to note that in Ft. McDowell a majority of the children attend public schools so how will they then be impacted by this law? We do feel that a priority activity should be given in the development of instructional materials about substance abuse in grades K-12.

In Sections 204, 205, we concur with Inter-Tribal Council of Arizona, Inc. (ITC), comment that they should be changed to include that "services developed under this section shall be coordinated with existing local programs."

Our comments on Title III - Family and Social Services, are that we acknowledge our CHR'S have received one week of substance abuse training through IHS which is addressed under Section 301. We concur that IHS should mandate substance abuse training which includes crisis intervention and family relations to BIA, IHS, school boards, parent advisory committees, child protective workers and others upon request. It is important that benefits of training BIA and IHS staff should not be a priority over direct services and preventive education for juveniles. Contracted tribal programs such as Ft. McDowell, should also have access to this training. This will require that Section 301 (b) (2) have a provision that employees of tribal human services programs have access to this training.

In Title IV - Law Enforcement, we concur with the intent of this section but we would like to know how the temporary emergency shelters will be funded and who will develop standards for them. It is important to make sure that the proposed legislation does not supercede tribal codes. We therefore concur with comments of ITCA that the language at 402 (a) (1) line 6 be changed to read ".... drugs or alcohol shall, when appropriate, detain such juvenile in a temporary emergency center ...."

In Title V Treatment and Rehabilitation of Children, no money has been allocated or authorized, even though IHS alcoholism services are currently under-funded. Where will the money come from for the new facilities discussed in this section?

In Title III - Definitions, Effective Date, and Authorization of Appropriations, our analysis of Section 603 is that 5 million dollars is not sufficient to carry forth the work of Titles II, III, and IV. We recommend that an excess of 5 million be authorized to meet the intent and provisions of all titles in this proposed legislation.

In summary, I would like to comment that this legislation has good intentions for our Indian youth who are our greatest resource. A current unmet need in our community is the development of on-going positive peer group activities that can be the basis for developing an alcohol and drug prevention program that meets the specific needs of the youth living in Ft. McDowell.

Louis Hood
Ft. McDowell Tribal Council Member

GILA RIVER INDIAN COMMUNITY
SACATON, AZ. 85247
ADMINISTRATIVE OFFICES
P. O. BOX 97 – (602) 562-3311

A STATEMENT FROM ARDELL A. RUIZ, ACTING DIRECTOR, GILA RIVER INDIAN COMMUNITY HUMAN RESOURCES DEPARTMENT/HEALTH BRANCH

TO

HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
RE: INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACCOUNTS

Mr. Chairman, members of the Committee, my name is Ardell A. Ruiz, I am the Acting Director of the Gila River Indian Community Human Resources Department/ Health Branch. I am speaking on behalf of the Gila River Indian Community as the representative for Donald R. Antone, Sr., Governor of the Gila River Indian Community.

The Gila River Indian Community lies between the largest metropolitan areas in Arizona - Phoenix and Tucson. An interstate freeway divides the reservation. Because of the proximity to the dominent culture, the disadvantages as well as the advantages of modern life are available to members of the Gila River Indian Community. One of the disadvantages affects of modern life is the erosion of traditional Pima/Maricopa values. This has resulted in a loss of cultural identity. Changing social conditions render some of the people in the Gila River Indian Community vulnerable to non-productive behavior such as alcohol and drug abuse.

In the Gila River Indian Community the children are particularly affected by substance abuse. They see substance-abusive behavior modeled by the significant adults and older siblings in their homes and in the community. Many young children are in homes without adequate supervision or attention. There is the natural curiosity of childhood to explore the environment and to try whatever experiences are offered by it. All of these factors contribute to the use of alcohol, other drugs, and inhalents by the youth of the Gila River Indian Community.

Tribal enrollment stands at 9,448 members. Young people under the age of 18 comprise 42% of the population in our community. Surveys done within the community show most young people have tried alcohol by age 15 and 12% of those surveyed admitted to regularly drinking 1 or 2 days a week. In addition to alcohol abuse, many youths are involved in the abuse/misuse of other chemical substances. Marijuana smoking among students in the Sacaton Middle School increased during the 83-84 school year while alcohol and inhalent abuse stayed relatively constant.

Law enforcement officials' contact with youth is precipitated by drugs/alcohol in most cases. For example, 70% of the juveniles convicted of joy riding in the Gila River Indian Community, and 45% of the chronic truancy violations are directly connected with alcohol or other drugs.

The Community Ambulance service reports that an excess of 80% of all traffic accidents involve alcohol. Further, they indicate that alcohol and substance abuse play an even larger role in assaults, homicides, suicides, and family violence.

As you can tell, the problem is of epidemic proportion and it is getting worse. Presently, there are no programs specifically dealing with Juvenile Alcohol and Drug Abuse prevention in the Gila River Indian Community. Our Alcohol and Drug Abuse Program employe one full-time staff member to work in the area of prevention and education. He provides services throughout all seven districts in the Gila River Indian Community and also to the people of the Ak Chin Indian Community.

The sheer magnitude of the task coupled with the diverse age group of the recipients requires a broad brush approach to substance abuse prevention and education. The unique and specific approaches which are effective with juveniles are ofentimes lost in the overall presentations.

In spite of the shrinking resources, our community maintains a system of coordination between Tribal Social Services, Health Services, Tribal Courts, Schools, and Law Enforcement. Indian Health Services and the Bureau of Indian Affairs, and off-reservation programs offer little help in addressing the problem of Juvenile Substance Abuse in our Community.

The Gila River Indian Community views the Indian Juvenile Alcohol and Drug Abuse Act - HR1156 as a good beginning. But only a beginning.

The $5,000,000.00 being proposed could easily be spent in our community alone. The amount ultimately authorized must be more realistic considering the overall goal of HR1156. Our Community also has concerns about the nature of the agreement between Indian Health Service and Bureau of Indian Affairs as required in Title I.

Our fear is that this agreement will require Indian Health Service and the Bureau of Indian Affairs to incur significant administrative expenses, which, when subtracted from the final authorization, will leave little resources to impact the Indian Juvenile Alcohol and Drug Abuse prevention problem.

The Gila River Indian Community will be forwarding a position paper to the House Committee on Interior and Insular Affairs within the next ten days. That report will be more in depth and contain specific recommendations.

Thank you for allowing me to address this Committee.

THE PAPAGO TRIBE OF ARIZONA
P.O. Box 837 • Telephone (602) 383-2221
Sells, Arizona 85634

Testimony of Papago Tribe of Arizona on H.R. 1156

Juvenile Indian Alcohol and Drug Abuse Prevention Act

Title I - Interdepartmental Agreement

The Papago Tribe of Arizona endorses in principle the provisions of Title I. to be effective a comprehensive program to deal with drug and alcohol prevention among Indian youth must involve integration of resources between Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA). Specifically, it is considered imperative that the focus of prevention activities be directed within the education system which serves as a primary locus for social activity among the youth.

Currently there are prevention activities conducted within the education system structure and the health care delivery structure, either at the community health level or the service unit level. However, BIA and IHS activities are largely conducted separately and in isolation of one another. Consequently, the positive effect of integrated coordination of resources is not brought to bear upon the identified problem. By virtue of the mandate for integration and coordination of activities and resources improved cooperative service delivery is ensured.

It is imperative that the direction of Title I, Sec 101 (b) (1), that Indian Tribes, individuals, and organizations be consulted with in the development of the agreement under Sec 101 (a) (1-6), be firmly adhered to. Further this consultation must be Tribally specific, and subsequent agreements Tribally sensitive. Individual Indian Tribes, due to uniqueness and cultural sensitivity, must determine level of need, focus of service, service delivery methodology, resource allocation, reporting and data collection/storage systems, and the appropriate mix of BIA, IHS, and Tribal Health Program involvement in direct service delivery.

The Papago Tribe feels strongly that with respect to Title I, Sec 102 (b) (1-2), the Tribal health program officials should have definitive decision-making authority in the identification and allocation of resources. Further, all program and resource reallocations must be in consultation with and upon agreement by Tribal health officials. In affect, insurance that the mass preponderance of fiscal appropriations be used for direct services rather than to support a bureaucratic superstructure must be built into the operating agreement. It is the opinion of the Papago Tribe that this can best be accomplished by focusing the development of

Interdepartmental Agreements on service delivery at the Tribal level under the most direct level of a Tribal health delivery or education organization.

Title II - Education

The Papago Tribe of Arizona concurs strongly with all elements of Title II, recognizing that adequately trained and professionally competent counselors are vital to the success of prevention activities.

It is felt however that curricula must be culturally sensitive to be relevant. No mention of developing culturally-sensitive curricula is made under Title II. This action does not necessitate modification of course and instructional material. Rather, this can most appropriately be accomplished by mandating that all curricula Include instructional sessions on making the counseling process and prevention-oriented media culturally relevant.

Title II Sec 205 (a) (1-3), providing for summer recreation and counseling programs, should include provisions which would ensure that the individual Tribe be responsible for the development of programs which have relevance to the identified needs of each individual Tribe. This, again, necessitates that the final decision for prevention activity/program development be assigned to the direct service delivery level.

Title III - Family and Social Services

The Papago Tribe of Arizona again agrees in principle with the provisions of Title III, recognizing the importance of prevention education and training for all Indian people. However, two important issues must be considered with respect to Title III Sec 301 (b) (1) (a-g) and (b) (2) (a-k). One, the all inclusive identification of training-eligible Indian persons, given the limits of fiscal resources, could lead to a dilution of quality in the nature and scope of prevention training. Consideration must be given to development of educational curricula specific to the functional and operational needs of Indian persons identified by category ((1) (a-g) and (2) (a-k)).

Two, based again on the all inclusive identification of training-eligible Indian persons, there is potential for serious abuse of the cost-value principle should the identified curricula not be appropriately geared to audience educational level and culturally relevant.

Consideration of these two issues will only reinforce the requirement for program development from the direct service delivery level upward through Tribal to BIA/IHS governmental and administrative levels.

Title IV - Law Enforcement

Title IV in general offers an excellent and apparantly culturally sensitive alternative to the incarceration of Indian youth arrested for an offense related to the abuse of drugs and alcohol, this in the form of emergency shelters or community-based treatment facility.

It must be emphasized that the Papago Tribe of Arizona would expect to be instrumental in the development of the guidelines made reference to in Title IV Sec 402, (a) (3). Tribal envolvement in the operational guidelines for law enforcement officials is imperative, particularly where law enforcement agencies are operated under PL 93-638 by the Tribe.

Further, the Tribe would expect to be instrumental in the development of the shelters' licensing requirements as discussed under Title IV Sec 402 (c) (2) (A). There does not appear to be a provision for Tribal involvement in the development of these standards under Title IV Sec 402 (3) (a). Since many tribal governments would prefer the use of community-based treatment facilities such involvement would be both imperative and essential.

Title V - Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation

Title V empowers the Director IHS to make three (3) determinations under Sec 501 which cannot be accomplished without significant Tribal involvement. Therefore, while participation, input, decision-making, and acceptance related to the proposed study by individual Indian tribes may be implied it should be clearly stipulated as part of the study process.

The Papago Tribe of Arizona, through its' Community Health Board would reserve the right to decide on the need for and location of a treatment facility on the Papago Reservation. The current writing grants this perogative to the Director IHS.

Title VI - Definitions, Effective Date, and Authorizations of Appropriations

The Papago Tribe of Arizona is concerned that the appropriation amount of $5,000,000. may be inadequate to meet the scope of work implied in the provisions of H.R. 1156. While studies of resource allocation are mandated both explicitly in H.R. 1156, it is strongly suggested that definite fiscal resource allocations studies be conducted following completion of prevention project design. Again, it must be emphasized that effective fiscal allocation should begin at the level of direct service delivery. Administrative support structure should be considered only after direct service imperatives have been met.

PASCUA YAQUI TRIBE

TESTIMONY OF THE PASCUA YAQUI TRIBE

"THE INDIAN JUVENILE ALCOHOL AND
DRUG ABUSE PREVENTION ACT"

JUNE 1985

7474 S. CAMINO DE OESTE • TUCSON, ARIZONA 85746 • (602) 883-2838

Testimony For The Indian Juvenile Alcohol And Drug Abuse Prevention Act

The Pascua Yaqui Tribe supports H.R. 1156, the "Indian Juvenile Alcohol And Drug Abuse Prevention Act." We ask support of Congress in assuring passage of this bill.

The Pascua Yaqui Tribe has become increasingly aware of the importance of effectively addressing the needs of Yaqui Youth in the area of "Substance Abuse".

DEMOGRAPHICS

The Pascua Yaqui Tribe has 5342 Tribally enrolled members with an additional 1274 pending members. (Attachment A) Tribal members currently reside in concentrated settlements. Yaqui communities eligible for IHS and BIA services provided through P.L. 93-638 contracts are:

New Pascua (Reservation, 892 acres) - 1,010 members located 15 miles southwest of Tucson.

Old Pascua -535 members located in Urban Tucson 17 miles north of New Pascua.

South Tucson (Barrio Libre)- 300 members located in Urban South Tucson 10 miles north of New Pascua.

Surrounding Tucson Area - 1,020 members.

Marana (Yoem Pueblo) - 175 members located 35 miles west of New Pascua. A rural farming community.

of the 1,010 members residing on reservation there are 233 males and 251 females under the age of 18 who are Tribally enrolled. Non Tribal members living on reservation include 11 males and 9 females. Currently the average age of Yaquis is 16.9 years. Approximately 52% of the total Yaqui population is 18 years or younger.

CURRENT SYSTEMS/PREVENTIVE PROGRAMS

Programs currently working with the Yaqui Youth are Social Services, Employment Assistance, J.O.M., Education, Health, Judicial, Law Enforcement and Pascua Yaqui Preschool.

The Pascua Yaqui Health Department has recently hired a Therapeutic Recreation Specialist to oversee the Youth Activities Program. The program is being funded by many sources: IHS Equity Funds (Mental Health, Alcohol, Health Education), ADAPT (State Drug And Alcohol Dollars), United Way (Local Community Dollars), Revenue Sharing, Community Block Grant, Private Foundation and Donations, Fund Raisers by the Youth.

The Program is staffed by a Therapeutic Recreational Specialist who has a background in Therapy and Counseling and Physical Education. He is assisted by two part time Yaqui Teen Peer Counselors.

The Program focus is to emphasize mental health promotion and drug and alcohol prevention activities and serve the developmental needs of the young people by reinforcing a positive self image, the ability to set personal goals and the ability to understand options and make choices. The youth activities are addressing issues of: goal setting, peer pressure, handlingsuccess, defeat, disagreement and confrontation. The Program provides healthy outlets in the form of: Karate classes, aerobics, nutrition, pottery and sculpture, weightlifting, beadwork, movies, group sessions with the Alcoholism/Drug Counselor, group sessions with the Adolescent Pregnancy Counselor/Health Educator and team sports (baseball, volleyball, basketball soccer). Field trips, geared toward education and career for potential job placement through Employment and Training or continuing education,are also offered. (Attachment B)

The Tribe is in the developmental stages, through its Youth Program, for prevention, early detection and intervention of behavioral problems among Yaqui Youth; since the absenteeism and dropout rate is high among Yaqui Youth.

The Therapeutic Recreation Specialist is coordinating with all Tribal Departments dealing with Youth. Special emphasis is being placed on counseling, education and discussion with individuals and groups for both young people and their parents.

Currently we are reaching 511 youth with over 3,000 contacts per quarter. The Youth Activities are being provided out of a Tribal Facility (2,000 sq. ft.). A gymnasium is currently under construction due for completion in October, 1985.

We have identified that 73% of Yaqui high school students and 32% of Yaqui jr. high school students have been involved in some form of substance abuse. Seventy-four (74) young people were suspended from school or referred for counseling in substance abuse related offenses. There is little evidence (.5%) of substance abuse at the elementary school level for Yaqui students. We feel strongly more attention needs to be directed to preventive programs at that level and even earlier at the preschool level.

SYSTEM COORDINATION

System coordination has been difficult. We feel much of that ties back to the manner in which funding is handled by various agencies - Federal (BIA-IHS), State, and Local funding. The need for such varied reporting (no uniformity between agencies) is a concern at the Tribal level. Funding allocations are often made without the Tribe determining the actual need. This results in funding being available for services that may not meet the needs of the program being provided. The final result then is fragmentation of services provided to the Youth on the Tribal level.

Although the Tribe has developed tighter inter-departmental coordination in regard to Youth, there are still many problems in coordinating with outside agencies; particularly when youth need foster care placement or have committed offenses off reservation. Those youth are referred to our Tribal Court or Child Welfare Worker. Problems have been encountered in obtaining all necessary information relating to that child from the various outside agencies dealing with the youth.

The Tribal Court System is in the process of developing an interjurisdictional agreement to provide "courtesy supervision" for children committing offenses off reservation. With the number of referrals from all sources that the Child Welfare Worker and Judicial System are receiving, there is not adequate staff to address the issues. The matter again ties back to the funding complexities especially in regard to BIA with indirect cost problems reducing direct services.

Another major concern is that Yaqui children attend Public Schools off reservation. There have also been jurisdictional problems relating to funding for Yaqui children. For example, the school system refers a Yaqui child to an outside agency for counseling. When the agency identifies the child as Indian, the issue then arises as to whether the child resides on reservation and the referral begins bouncing around. The outside agency tries to determine what Tribe the child is a member of and if there is an agency on reservation that will handle the referral. Many times the school assumes if a program does exist on reservation that outside resources are not needed, when in fact the on reservation program may not have adequate staff or funding to handle the referral. At that point the reservation program starts the process all over trying to find someplace to handle the needs of the child. Many times the referral never makes it to the reservation programs because the outside agency gets so frustrated with being shuffled from one agency to another and the child doesn't receive any service. If in fact the outside agency does hang in and other agencies become involved, the counseling may not be consistent from agency to agency.

Teachers, counselors and even some Indian staff, hired in school systems with federal dollars, have often times also be found to label or assess Yaqui students by "standards" that may apply for other Native Americans or Tribes but don't in any manner address Yaqui Culture.

In the Tucson Unified School District there are 1224 Indian students (all Tribes). Of that number, 715 are Yaqui students about 58% of the total enrollment. They attend Lawrence, Richey, Missionview Elementaries, Wakefield, Pistor, Mansfeld Jr. Highs, and Tucson, Pueblo and Cholla High schools. We feel that with the high concentration of Yaqui Youth the school staffs need training that would be Yaqui specific, in dealing with our Youth in the areas of substance abuse. Training needs to be on all levels from administration down to classroom aides. Marana, our most distant community, has even different problems mostly related to access to Tucson agencies.

UNMET NEEDS

The Pascua Yaqui Tribe sees a need for the Youth that have already become offenders or users in the area of substance abuse. A recent problems with heroin addition, in one Yaqui community, brought to light the problem of the lack of treatment dollars and facilities for treatment.

Currently we have an agreement with the Gila River Juvenile Detention Center (130 miles one way) to detain Yaqui Youth. The distance and lack of adequate space has caused problems. There is a need in the Tucson area of a temporary or even a permanent placement in regard to Foster Care Homes. Homes are available for babies and young children but after age 10 Foster Care Placement is difficult. Youth placed on probation, because of inadequate staff, lack proper follow up. There is a definite need for a facility. It could be a shared Tribal Facility but consideration needs to be given to where facility should be placed.

TRAINING

We feel training must be available on all levels, beginning with the parents and continuing all the way up to the Bureau level. We feel that all Tribal Staff that come in contact with families and children must have basic training that will make them aware of early signs of substance abuse problems so that help can be offered.

TITLE I - INTERDEPARTMENTAL AGREEMENT

We support the provisions of Title I providing for coordination of BIA and IHS programs in the identification of available resources and to reinforce implementation with maximum Tribal participation.

TITLE II - EDUCATION

We support the provisions of Title II. We sould like to see added assistance in gaining better access to the Public School System with the provision of special training of counselors and school staff in the area of drugs and alcohol. We would like to see more active support and participation of the BIA in easing contractural arrangements to provide more flexibility in providing comprehensive summer programs to the youth.

TITLE III- FAMILY SERVICES

The Pascua Yaqui Tribe has a concern in the area of training. The Tribe feels any training provided under provision of Title III must be tailored to meet specific Tribal and logistic needs. Traditionally training has been provided by BIA or IHS on a National Level and we feel it would be more relevant if addressed and provided on a local level (since many areas have resources or trainers nearby with programs to fit the needs of the specific region or area, they should be utilized).

Although it is probably understood, nowhere are Tribal programs or personnel under Title III specifically addressed.

TITLE IV - LAW ENFORCEMENT

We support the ideas and recognize the need for an active role by law enforcement. However, again because of logistics and the great variance of Tribal specific needs we feel as Title IV is currently stated it may be too restrictive.

TITLE V -TREATMENT AND REHABILITATION OF CHILDREN

As stated in unmet needs for the Pascua Yaqui Tribe the only facility for detention of juveniles is Gila River, 130 miles one way. We feel the issue of detention or rehabilitation facilities is necessary since even with strong emphasis on prevention there will still be Youth in need of care and treatment.

ATTACHMENT A

PASCUA YAQUI TRIBE

January 29, 1985

TO: MR. SAMUEL HILLARD/ CONTRACTING OFFICER'S REPRESENTATIVE

FROM: MS. CARMEN L. ALVAREZ/ENROLLMENT OFFICER
PASCUA YAQUI TRIBE

UPDATE ON YAQUI COMMUNITIES FOR JANUARY 29, 1985

Pima County
3,040

*	NEW PASCUA PUEBLO	902	+ 108 = 1010
*	SOUTH TUCSON &	300	
*	CITY OF TUCSON	1020	
*	OLD PASCUA	535	
*	YOEM PUEBLO	175	
**	GUADALUPE	1209	
**	STANFIELD	30	
**	CASA GRANDE	41	
**	CHANDLER	42	
**	COOLIDGE	87	
**	ELOY	52	
**	PHOENIX	204	
**	GLENDALE	19	
**	SCOTTSDALE	139	
**	MESA	31	
**	TEMPE	53	
**	PEORIA	16	
	SURROUNDING AREAS IN AZ.	174	
	OUTSIDE THE STATE OF AZ.	313	
	TOTAL	5342	

* Yaqui's residing in Pima County are eligible for Contract Health Services "on or near" reservation

** Yaqui's eligible for Direct Services at Phoenix Indian Health Center only

7474 S. CAMINO DE OESTE • TUCSON, ARIZONA 85746 • PHONE (602)883-2838

MONTHLY SCHEDULE FOR SUMMER YOUTH ACTIVITIES

ACTIVITIES WILL BE HELD IN THE DOME AND ARE OPEN TO THE OTHER COMMUNITIES ---- JUNE 1985

ATTACHMENT B

SUN	MON	TUES	WED	THRUS	FRI	SAT
ATTN: YOUTH COMMUNITY NEW SUMMER HOURS ----- STARTING, JUNE 5, 1985 FROM 1:00 p.m. TO-10:00 p.m.						1
2	3 Outdoor Rec. 1-10 Aerobic 4:45 to 5:45	4 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 O.Pascua/Movies	5 Arts & Craft 4-6 Aerobic 4 45-5:45 Marana/Arts&Craft 5:30-9:00 Outdoor Rec. 1-10 Marana/Movies	6 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 S.Tucson/Movies	7 Outdoor Rec. 1-10 NEW PASCUA MOVIE	8
9	10 Outdoor Rec. 1-10 Aerobic 4:45 to 5:45	11 Karate/YWCA 3:30-5:30 Outdoor Rec. 1-10 Arts&Craft 4-6 O.Pascua/Movies	12 Aerobic 4:45-5:45 Arts & Craft 4-6 Marana/Arts&Craft 5 30-9:00 Outdoor Rec. 1-10 Marana/Movies	13 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 S.Tucson/Movies	14 Outdoor Rec. 1-10 NEW PASCUA MOVIE	15
16	17 Outdoor Rec. 1-10 Aerobic 4:45 to 5:45	18 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 O.Pascua/Movies	19 Outdoor Rec.1-10 Aerobic 4:45-5:45 Arts & Craft 4-6 Marana/Arts&Craft 5:30-9:00 Marana/Movies	20 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 S. Tucson/Movies	21 Outdoor Rec. 1-10 NEW PASCUA MOVIE	22
23 30	24 Outdoor Rec. 1-10 Aerobic 4:45-to 5:45	25 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 O.Pascua/Movies	26 Outdoor Rec.1-10 Aerobic 4:45-5:45 Arts & Craft 4-6 Marana/Arts&Craft 5:30-9:00 Marana/Movies	27 Karate/YWCA 3:30-6:00 Outdoor Rec. 1-10 S. Tucson/Movies	28 Outdoor Rec. 1:10 NEW PASCUA MOVIE	29

Salt River
PIMA-MARICOPA INDIAN COMMUNITY
ROUTE 1, BOX 216 / SCOTTSDALE, ARIZONA 85256 / PHONE 949-7234

IN REPLY REFER TO: Administration

June 6, 1985

Mr. John Lewis,
Inter Tribal Council of Arizona
124 West Thomas Road, Suite 201
Phoenix, AZ 85013

Dear John:

Please be advised that due to my absence, Mr. Elton Yellowfish will be providing testimony for this Community on the hearing scheduled in phoenix on June 15, 1985 on the Indian Juvenile Alcohol and Drug Abuse Prevention Act. Mr. Yellowfish will be making oral and written testimony.

As with other Indian Communities, we are vitally interested in the welfare of our juveniles. Anything that can be done to develop and fund programs to curb alcohol and drug abuse should be given priority attention.

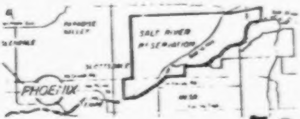
Sincerely yours,

Gerald Anton,
President

GA/sj

cc: Mr. Elton Yellowfish

SALT RIVER INDIAN RESERVATION



# COMMENTS
from
Salt River Pima-Maricopa Indian Community
concerning
Indian Juvenile Alcohol and Drug Abuse
Prevention Act, (HR6196)

Prepared by
Elton C. Yellowfish
Tribal Health Planner

I. Background

In an Indian community where an estimated 50% of the population is below 18.6 years of age, Salt River is definitely concerned about its young people. The nearness of Salt River to metropolitan Phoenix, Scottsdale, Mesa, and Tempe, Arizona are an additional cause for concern because this represents a changing environment for Indian youth.

Salt River Indian Reservation is located in Maricopa County, East of Scottsdale and North of Mesa Urban communities with a 1984 tribal population of 4,075. The reservation encompasses 52,000 acres of land of which a majority is used for agricultural purposes. Ninety five percent of the population live on the reservation with an unemployment rate of 39%.

Salt River Pima-Maricopa Indian Community was established as a result of a series of federal Executive Orders dating from 1879 to 1972. The present day Pima Indians are descendants of an ancient tribe of people called the "Ho-Ho-gam", meaning vanished. They lived throughout the Gila and Salt River valley. Their lifestyle consisted of farming through use and delivery of water from irrigation channels derived from the Salt River. ~~[illegible] Gila and Colorado Rivers area~~. ~~They eventually dwelled among the Pimas including the sharing of domestic and protective responsibilities~~.

Salt River's residential youth (K-6th grade) attend the Bureau of Indian Affairs, Day School located on the reservation. Mesa Public School system accepts a majority of students from the 7th grade through high school. Some students attend Scottsdale Public Schools, Phoenix Indian School, and Sherman Indian School in Riverside California. Mesa School Indian Student Office reports a total of 1,217 students from K-12th grade for school year 1984 and 1985. Ninety-eight percent of this amount is assumed to be from Salt River.

In 1975, Salt River experienced its first juvenile delinquency prevention program. Its immediate goal was to work with Salt River Indian youth before their behavior reached the point of judicial intervention by authorities. During its three-year existence, the program had nearly 400 youth involved in activities of competitive recreation, field trips, drop-in center facility, and informal "rap sessions". Program funding was provided through the Department of Justice, Law Enforcement Assistance Administration and eventually, the Salt River Tribal Council. The primary focus was on diversion, or alternative programs conducted in a supervised group setting rather than crises counseling. Because of a lack of funds, the program ended.

The Johnson O'Malley Program began in 1976 at Salt River and currently provides tutoring and summer school for over 400 Salt River Indian youngsters from K-12th grade. Along with academic emphasis, this year special attention will be centered on classes in self-awareness, family and community, and culture comparison.

II. Present Condition

During calendar year 1984,two program proposals were prepared and submitted for possible funding consideration. Both proposals were denied. Action Volunteer Agency, Washington D.C., rejected $8,900 for a proposed 12-month pilot project for early intervention among adolescent youth experiencing substance abuse problems at Salt River. The Arizona State Department of Corrections also rejected a similar pilot project in the amount of $3,840.

The need for alcohol and drug programs is reflected in the following major program areas.

A. Salt River Social Service Department (Alcohol related figures from December 1984 to April 1985)

1.	Children placed in Foster Care Programs:	16
2.	Off reservation residential treatment facilities placement for children:	11
3.	Youth Home placement at Salt River:	2
4.	Children who sniff paint and use alcohol:	12
5.	Court custody cases:	10
6.	Child abuse:	60
7.	Domestic violence:	10

B. Alcohol Prevention Research Project

A special IHS funded project whose purpose is to establish a network identification system that involves primary alcoholics and potential high-risk individuals associated with the primary alcoholic. A total of 20 youths (16 male and 4 female) were identified during a period from December 1984 to May, 1985. Special efforts were made to maintain strict client confidentiality. A graph is enclosed for further examination. The total 20 youths, is not conclusive. This amount only reflects the result of a concentrated effort and study.

C. Salt River Youth Home

Enclosed for further examination is a recent 12-month report of youth residents. Among the conclusions is the fact that 68% of the residents were involved in alcohol or drugs either during or before placement. Salt River Youth Home maintains placement for tribal youth who are referred through the Tribal Court, Tribal Social Service Department and other related agencies who work with problem youngsters.

In a separate interview with Edward Reina, Jr, Chief of Police, Salt River Department of Public Safety, Mr. Reina indicates, "Juveniles have always been a problem. It is a priority". Police records indicate juvenile delinquent activity to be on the rise again. A year ago, the department was processing 80 youth. Prior to that, some 300 Salt River juveniles were in some kind of trouble with the police. A copy of procedures for juveniles is enclosed.

Delbert Ray, Tribal Probation Officer points out that sniffing is the primary problem among Salt River youth. Mr. Ray's job is directly related to the Tribal Court and Tribal Police. He provides counseling, referrals, and filing of reports. This statement is reinforced by Mr. Merrill Smith, Counseling Coordinator, Indian Education, Mesa Public School, "Inhalants are our number one problem". A copy of "Arrest and Detention of Children" is enclosed. This page is a part of the Tribal Law and Order Code that is used for enforcement purposes.

III. Future Plans

Salt River visualizes a plan that will implement a comprehensive youth program aimed at prevention and early intervention. Salt River's governing body is in total support of providing this type of program for its young people. Evidence of this effort is found within the following portion of the Specific Population Plan, FY-1986: (submitted to Arizona Department of Health Services).

> "Children and Youth-Since February 1985, Salt River Alcohol Program has been able to focus on young people. Prior to this, no specific structured activity was available for Indian youth experiencing alcohol or drug problems. General group sessions are now in effect, meeting once a week for Salt River Indian Youth attending Mesa Public School. . . . Salt River Alcohol Program will continue its role as being a primary advocate for substance abuse related services among young people."

Salt River Health Planning Department will continue to seek and identify program funding in an effort to establish youth prevention direct services on a more firm basis. This includes coordinating with funding agencies on local, state, and federal levels.

"What we need are program experts", states Bob Lewis, Director of Tribal Social Service. "We need a systematic approach in coordinating services for the young people."

Winifred Paisano, Coordinator for Salt River Alcohol Program says, "Indian youth need the opportunity for services that we provide for adults. Youth programs need to be stable and not temporary."

IV. Comments on Indian Juvenile Alcohol and Drug Abuse Prevention Act (listed in priority)

1. Appropriations - Funding for Titles II, III, and IV is crucial. Proposed five million is not sufficient in light of a nationwide effort to address a problem that has been either neglected, overlooked, or forgotten.
2. Coordination of BIA and IHS - This relationship is practical on a programmatic level. Because both BIA and IHS have separate operating budgets, the coordination of these agencies for this purpose does not seem realistic.
3. Family and Social Services - Training for tribal employees must be given priority over regular BIA and IHS staff training.
4. Law Enforcement - Juveniles who are apprehended must be protected. Not all juveniles need incarceration. Consideration must be given for parental involvement. Emergency situation language must be incorporated into this law.

V. Conclusion

1. Salt River is a young rural population. Its philosophical approach is with caution. It is conservative in nature. Within the past 10 years, Salt River has progressed at a medium pace through means of Public Law 93-638, tribal management of direct services to its Tribal members. Tribal self sufficiency is the long range goal, but it can not maintain self sufficiency if its tribal youth are in turmoil because of alcohol or drugs. It is these same youngsters who someday will be a part of the decision-making process for this community. The future of the tribe could very well be at stake.

2. The nearness of Salt River to Phoenix is unique and troublesome. It's unique because it provides modern conveniences and shopping centers to the reservation people. It's trouble-some because it provides for an easy flow of alcohol and drugs.
3. Alcohol and drugs are a significant problem. It is not overwhelming, but could be out-of-control if nothing is done. Thus, the strive toward a preventive approach in dealing with Salt River youth.
4. Tribal Codes and Tribal Enforcement are in place that provide ways and means of handling Salt River problem youths. Tribal program directors are keenly aware of, "no real program for our young people who experience problems". While work is being performed, much more support, treatment, and follow-up is vitally needed.

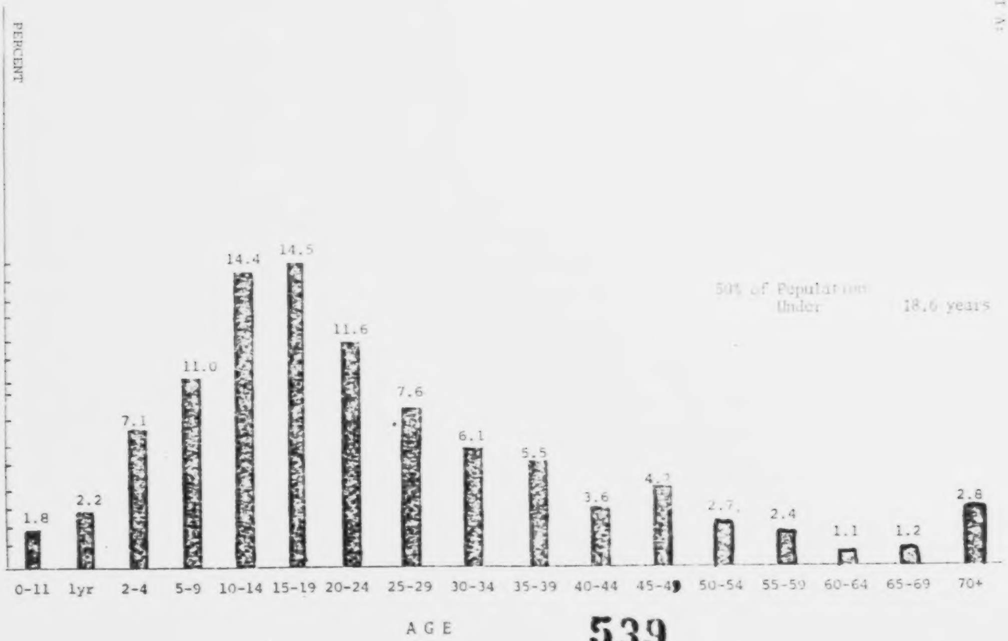
VI. Recommendations

1. Salt River Indian Community agrees with the intent of HR 6196-- "to coordinate and expand services . . . . among Indian youth . ." Therefore, we recommend the passage of this bill, for the following reasons!
    a. Salt River has no youth program for alcohol or drug related problems. Passage of this bill will allow opportunity for initial funding and program start-up.
    b. Salt River needs this type of law as a tool or instrument that can be utilized on behalf of the tribe in its quest for program funding and its desire to respond satisfactory to critics: alcohol and drugs abuse among Native Americans is a concern nationwide.
2. Salt River Indian Community recommends total appropriation at a level of $20 million.
3. Salt River Indian Community recommends tribal programs be given a priority of additional training in the areas of prevention, identification, treatment, and follow-up care of alcohol and drug abuse among Indian youth.

HEALTH AND DEMOGRAPHIC SURVEY
SALT RIVER INDIAN COMMUNITY
July 1983

ATTACHMENT A:

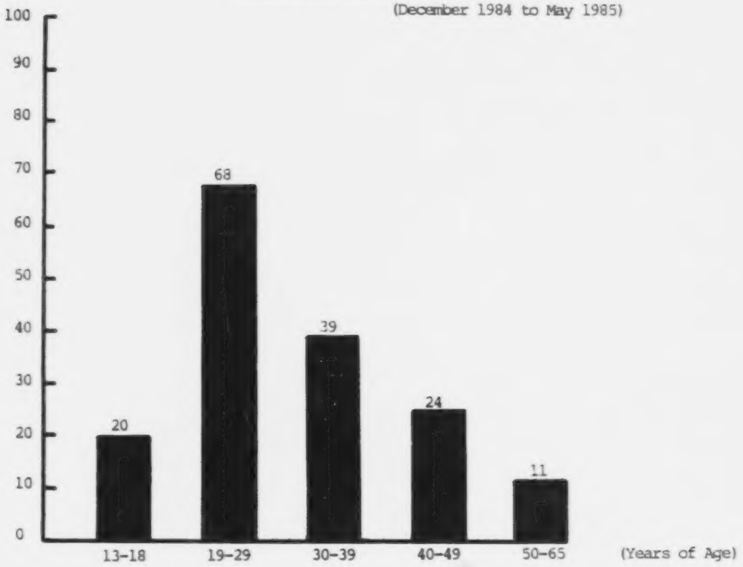
PERCENT POPULATION
BY AGE GROUP



50% of Population
Under 18.6 years

Alcohol Prevention Research Project

(December 1984 to May 1985)



Note: Potentially high risk Indian Juveniles who has some family member involved as an alcoholic. This identification will be used as resource in future contacts with families or direct individuals.

ADMISSION RECORD - SALT RIVER YOUTH HOME
May 1984 to May 1985

	Male/Female	Age of Child	Child using Alcohol during & before placement	Child using inhalents during & before placement.	Present alcohol abuse by family members contributing significantly to child placement.	Other immediate problems con-contributing to placement.
1.)	Female	14		X		X
2.)	Male	14	X	X		X
3.)	Male	14				X
4.)	Male	12	X	X	X	
5.)	Female	16				X
6.)	Male	14	X	X		X
7.)	Male	13				X
8.)	Female	13				X
9.)	Male	15	X	X		X
10.)	Female	14				X
11.)	Male	10	X	X		X
12.)	Female	14		X	X	
13.)	Female	15		X		X
14.)	Female	13		X	X	
15.)	Female	13	X			X
16.)	Male	12		X	X	
17.)	Male	12	X			X
18.)	Male	14	X	X		X
19.)	Male	15	X	X	X	
20.)	Male	17	X	X		X
21.)	Female	16				X

[illegible] MIS [illegible] RE [illegible] R YO [illegible] HOM
May 1984 to May 1985

Male/Female	Age of Child	Child using Alcohol during & before placement	Child using inhalents during & before placement.	Present alcohol abuse by family members contributing significantly to child placement.	Other immediate problems contributing to placement.
22.) Female	13	X	X		X
23.) Female	16				X
24.) Female	14				X
25.) Male	15		X		X
26.) Female	8		X	X	
27.) Female	9		X	X	
28.) Female	14				X

SALT RIVER TRIBAL POLICE DEPARTMENT
(copy)

ARREST & INTAKE OF JUVENILES

To minimize and effectively divert juveniles away from the juvenile justice system, the following procedures have been set up and will be strictly followed.

An officer's discretion, upon contact with a juvenile offender, is a very critical and important element for diverting the juvenile away from the justice system and perhaps will deter the juvenile from committing any further criminal acts.

Therefore, the officer, upon initial contact with a first offender and after taking into consideration the guidelines set in section F.1-3 of this policy will:

A. Advise the juvenile of the offense and the reason for detainment.

B. Appropriate warnings will be directed toward the juvenile encompassing the type of penalty he/she may be subject for committing the offense.

C. Be entirely certain that the juvenile understands all the facts about the offense. Also, any questions he may have are clearly explained.

D. The juvenile will be released with the understanding that should he/she committ any other offense he/she will have to suffer the consequences of the act.

These procedures, of course, will be used only when there is no property loss or vandalism in this latter situation the victims will be contacted and appropriate action will follow. Again, the officer's discretion is used and all attempts to settle the matter will be made before making an arrest or referral.

In all other situations the following policies will be followed.

A. A child may be taken into custody by any peace officer or juvenile probation officer pursuant to order of the court.

B. A child may be taken into custody by a peace officer without order of the court.

  1. When in the presence of the officer, the child has violated a State, Federal, or Community law or ordinance.

  2. When there are reasonable grounds to believe that the child has committed an act, which if committed by an adult, would be a felony or other crime.

C. When an officer takes a child into custody, he shall abide with the following:

  1. Inform the juvenile of his right to remain silent and anything he says can be used against him in court. He has the right to the presence of an attorney during questioning, and if he cannot afford an attorney, the court will help him obtain one through available Tribal services.

2. The child shall not be detained any longer than is reasonably necessary to obtain his name, age, residence, and other information, and to contact and obtain the appearance of his/her parents or guardians. The parent or guardian will be advised of the reason for detainment.
3. The child will be released to the custody of a parent or guardian after explaining the circumstances for detainment, unless the child is in need of emergency medical treatment, requests protective custody, or is known to be in a fugitive status.
4. Whenever a child is not prompty released, the officer shall promptly inform the juvenile officer of the facts regarding the arrest.

D. The juvenile officer will determine if further detainment is necessary. If not, he will order the release of the child. If the child is to be held, it will be in a facility:

1. Designed specifically for detention of juveniles, which will have available prior to detainment, a 24-hour intake screening procedure.
2. The intake screening officer, after again reviewing the matter, may order release of the juvenile or may seek alternative placement of

the juvenile.

E. The holding of an arrested child in any adult detention facility is strictly prohibited.

F. The officer should release the juvenile unless clear and convincing evidence demonstrates that continued custody is necessary. The seriousness of the alleged offense should not, except in cases involving murder, be sufficient grounds for continued custody. Such evidence should consist of one or more of the following factors:
   1. The juvenile is in a fugitive status.
   2. The juvenile has a recent record of willful failure to appear at court proceedings.
   3. That the child is charged with a crime of violence, which in the case of an adult is a felony, and is already under the jurisdiction of the court.

G. When any juvenile engages in non-criminal misbehavior and an officer if he determines the child is in immediate danger may take the child into limited custody and immediately contact the parent and release the child to the same or a responsible adult.

H. If the law enforcement officer is unable by all reasonable efforts to contact the parent, relative, or other responsible person, or if the person contacted lives at an unreasonable distance, or if the juvenile refuses to be taken to his or her home or other appropriate residence, or if the officer is otherwise unable to make arrangements for the safe release of the juvenile, the officer shall take the child to a designated temporary nonsecure residential facility approved by the Tribe.

I. When any juvenile, as a result of mental or emotional disorder, or intoxication by alcohol or other drug, is suicidal, seriously assaultive or seriously destructive, or otherwise evidences an immediate need for emergency phychiatric or medical evaluation and possible care, any officer may upon reasonble cause take or cause to be taken, such juvenile into emergency custody and take the child to a facility approved by the Tribe as a facility for emergency evaluation and treatment.

Detention of dependent, neglected, or abused children:

A. Dependent, neglected, or abused children will never be held in detention.

B. A child may be taken into custody by any peace officer without order of the court:

   1. When he/she is seriously endangered in his surroundings and immediate removal appears to be necessary for his protection.

2. When there is reason to believe that the child requires immediate care or medical attention.

C. Detention will be only in a community based group home, shelter care home, or any non-secure facility approved by the Tribe.

shall be complete upon return to the court of the signed receipt.

(2) If the address or whereabouts of the parent or guardian outside community lands cannot, after diligent inquiry, be ascertained, by publishing a summons in a newspaper having general circulation on community lands. The summons shall be published once a week for three (3) successive weeks. Service shall be complete on the day of the last publication.

Time limit. In the case of service on community lands, service completed not less than forty-eight (48) hours before the time set in the summons for the appearance of the person served shall be sufficient to confer jurisdiction. In the case of service outside community lands, service completed not less than five (5) days before the time set in the summons for appearance of the person served shall be sufficient to confer jurisdiction.

k) *Warrant for arrest.* If the summons cannot be served, or if it appears to the court that the person served will not obey the summons, that serving the summons will be ineffectual, or that the welfare of the child requires that he be brought immediately into custody of the court, a warrant may be issued for the arrest of the parent, the guardian, the custodian or the child, and any such warrant may be served anywhere within the jurisdiction of the court.

l) *Warrant to search for child.* If it appears to the court upon an affidavit sworn to by a peace officer or any other person, and upon the examination of other witnesses if required by the judge, that there is probable cause to believe that a child is being detained or ill-treated in any place within the jurisdiction of the court, the court may issue a warrant authorizing a duly authorized peace officer or probation officer to search for the child. Upon serving such warrant upon the person in possession of the premises specified in the warrant, the peace officer making the search may enter the house or premises, by force, if necessary in order to remove the child. The officer must thereupon take the child to the court or the place of detention or shelter designated by the court in accordance with section 11-26. (Code 1976, § 12.11(e))

Sec. 11-26. Arrest and detention of children.

(a) *By court order.* A child may be taken into custody by any peace officer or probation officer pursuant to an order of the court.

(b) *Without court order.* A child may be taken into custody by a peace officer or probation officer without order of the court:

(1) When in the presence of the officer the child has violated a. state, federal or community law or ordinance;

(2) When there are reasonable grounds to believe that he has committed an act which, if committed by an adult, would be a felony;

(3) When he is seriously endangered in his surroundings, and immediate removal appears to be necessary for his protection;

(4) When there are reasonable grounds to believe that he has committed an act, which, if committed by an adult, would be a breach of peace; or

(5) When he has reason to believe that the child requires immediate care or medical attention.

(c) *Notification of parent/guardian.* When an officer takes a child into custody, he shall immediately notify the parents, guardian, or custodian.

(d) *Time limit upon detention.* A child shall not be detained by the community police any longer than is reasonably necessary to obtain his name, age, residence and other information, and to contact and obtain the appearance of his parent, guardian or custodian. A peace officer, other than the probation officer, who arrests a child under the age of eighteen (18) years shall forthwith notify the probation officer, and shall make such disposition of the child as the probation directs. No child shall be held in the detention for more than twenty-four (24) hours excluding Saturdays, Sundays and holidays, unless a petition alleging delinquent conduct has been filed; and no child shall be held longer than twenty-four (24) hours excluding Saturdays, Sundays, and holidays, after the filing of said petition, unless so ordered by the court after a hearing.

(e) *Filing of brief upon detention.* The officer or other person who takes a child to a detention shall promptly file with the court a brief written report stating the occurrences or facts which bring the child within the jurisdiction of the juvenile court and giving the reason why the child was not released.

(f) *Hearing date.* After an investigation by a duly authorized officer of the court, the judge or other authorized officer with or without a hearing shall, upon written promise to bring the child to the court at a set time or, without restriction, order the release of the child to his parents, guardian or custodian if it is found that he can be safely left in their care. If it is found after a hearing for that purpose that it is not safe to release the child, the judge or authorized officer may order that the child be held in an appropriate facility, subject to further order of the court. (Code 1976, § 12.13)

Sec. 11-27. Investigation and hearing.

(a) *When investigation required.* After adjudication that a child is delinquent, dependent, neglected and/or incorrigible, the court may require that a social investigation be made and that a report be submitted to the court in writing in all cases under section 11-15 in which a petition has been filed.

(b) *Scope of investigation.* The investigation shall cover the child's home environment, history and associations, the present conditions of the child and family, and recommendations as to the child's future care. In cases involving the duty of support, the study shall include such matters as earnings, assets, financial obligations and employment.

(c) *Proceedings to constitute civil proceeding.* Proceedings in children's cases shall be regarded as civil proceedings, with the court exercising certain equitable powers. Nevertheless, the fact that the proceedings are of civil nature shall not be construed to deprive the child of his rights to counsel, to confront accusers and to cross-examine witnesses against him, nor to deny him his privilege against self-incrimination.

(d) *Manner of hearing.* Hearings in children's cases shall be before the court without a jury and may be conducted in an informal manner. The general public shall be excluded and only such persons as the judge finds have a direct and legitimate interest in the case or in the work of the court shall be admitted. At the discretion of the court, the child may be separately interviewed at any time if represented by his counselor. The hearing may be continued from time to time to a date specified in the order.

(e) *Keeping of records.* The record of the proceedings shall be kept in accordance with the practice in civil cases before the community court of the Salt River Pima-Maricopa Indian Community, unless the court otherwise directs.

(f) *Admissibility, destruction of record.* Neither the record in the juvenile court nor any evidence given therein shall be admissible as evidence against the child in any proceedings in any other court. No child shall be charged with crime nor be convicted in any community court except as provided in this Code. Upon reaching the age of eighteen (18) the child's record shall be destroyed.

(g) *Right to counsel.* Any party, including the community, shall have a right to be represented by a counselor in any proceeding under this Code. Prior to any hearings, the court shall inform the parents, guardians or custodian, and the child when it is appropriate to do so, that they have a right to be represented by a counselor. The counselor shall be any person permitted to appear before the Salt River Community

White Mountain Apache Tribal Juvenile Court

P.O.Box 1570
Whiteriver, Arizona 85941
Telephone (602) 338-4331

KAY ANTHONY LEWIS
Juvenile Judge

PHILLIP L. SMITH
Juvenile Probation Officer

ELIZABETH SANCHEZ
Juvenile Court Clerk

May 29, 1985

Morris Udall
Chairman
House Committee on
Interior & Insular Affairs
235 Cannon House Office Building
Washington, D.C. 20515

Dear Honorable Udall

On behalf of the White Mountain Apache Tribe request to appear before the House Committee hearing schedule for June 15, 1985 in Phoenix, Arizona, to present testimony of some of our concern and needs related to Bill H.R. 6196 Indian Juvenile Alcohol and Drug Abuse prevention. Enclosed you will find the statement to be presented. Thank You.

Respectfully,

Kay A. Lewis
Juvenile Judge

xc: Ronnie Lupe
Tribal Chairman

STATEMENT MADE TO: HONORABLE MORRIS UDALL, CHAIRMAN AND MEMBER OF THE
HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
235 CANNON HOUSE OFFICE BUILDING, WASHINGTON, D.C.

PLEASE PERMIT ME TO INTRODUCE MYSELF. MY NAME IS KAY ANTHONY LEWIS, JUVENILE JUDGE FOR THE WHITE MOUNTAIN APACHE TRIBAL JUVENILE COURT, WHITE-RIVER, ARIZONA. I AM VERY HAPPY TO BE HERE WITH YOU TODAY. THANK YOU FOR ALLOWING ME TO COME. WHEN I STARTED TO PREPARE MY SPEECH AND TO DO SOME HOMEWORK ABOUT THE FEDERAL GOVERNMENTS PART IN IMPROVING THE LIVES OF INDIAN YOUTH, I BEGAN TO FEEL OVERWELMED BECAUSE OF THE UNIQUE RELATIONSHIP BETWEEN THE INDIAN TRIBES AND THE FEDERAL GOVERNMENT. THE GOVERNMENT SEEMS TO BE INVOLVED IN SO MUCH OF THE EDUCATION, HEALTH AND SOCIAL SERVICES DELIVERY THAT IMPACT ON THE INDIAN YOUTH. THE FEDERAL GOVERNMENT MUST CONTINUE TO COMMIT ITSELF TO PROVIDE, NOT JUST DOLLARS, BUT SENSE. I MEAN THE SENSE OF HEARING SO THAT THEY LISTEN TO INDIAN TRIBES AND FIND OUT WHAT IS NEEDED TO BE IMPROVED ON THE RESERVATION.

I REALIZE THAT I HAVE BEEN INVITED BECAUSE OF MY INTEREST AND CONCERN ABOUT THE INCREASING ONE OF THE GREATEST KILLER THAT CONFRONT INDIAN YOUTH IS ALCOHOL AND DRUG ABUSE. BEFORE SUCH ABUSE CAN BE EFFECTIVELY DECREASED, WE NEED TO OBTAIN MORE FUNDS FOR ALCOHOL AND DRUG ABUSE PREVENTION TO ELIMINATE ALL OF THE BAD OR WEAK POINTS. FOR YEARS EFFORTS TO CURB ALCOHOL AND DRUG ABUSE BY LAW ENFORCEMENT ALONE HAVE FAILED. BETTER TRAINING AND AN APPROPRIATE OUTLOOK ARE NECCESSARY. THE FEDERAL GOVERNMENT MUST BECOME INVOLVE IN THE RESOLUTION OF PROBLEMS ON THE RESERVATION AND IN THE TREATMENT PROCESS FOR THE INDIAN YOUTH.

ONE OF THE MOST CRITICAL PROBLEMS IN TRYING TO BRING ABOUT CHANGE IN EFFECTING INDIAN YOUTH ON THE RESERVATION HAS BEEN THE INABILITY TO DEVELOP SUCH PREVENTION TREATMENT PROGRAM, DUE TO THE TRIBE'S FINANCIAL RESOURCES ARE EXTREMELY LIMITED. ALCOHOL AND DRUG ABUSE PREVENTION TREATMENT PROGRAM

IS NEEDED IN THE FUTURE TO HELP KEEP INDIAN YOUTH ON THE RESERVATION STRIVE TO OVERCOME THEIR PROBLEMS, ADJUST TO THE REALITIES OF LIFE PROTECTING THEM AND KEEPING THEM FROM BECOMING CRIMINAL AS ADULTS AND REHABILITATING THEM.

I WANT TO THANK YOU FOR INVITING ME TO SPEAK AND TO SHARE WITH YOU MY CONVICTION CONCERNING THE NEEDS OF INDIAN YOUTH. I HAVE BEEN HONORED IN BEING ASSIGNED THESE DIFFICULT RESPONSIBILITIES AND I HOPE THAT IN SOME SMALL WAY - PROGRESS WILL BE ACHIEVED TO REAFFIRM OUR COMMITMEMT TO PROTECT INDIAN YOUTH AND WE MUST BE PREPARED TO ACT AS PARTNERS.

THANK - YOU!!

Testimony of

The Papago Peer Counseling Group

on

HR. 1156

Title I. Interdepartmental Agreement

The Papago Peer Counseling Group endorses the principles of the provisions of Title I. As youth, we realize that to be effective, an alcohol and drug abuse prevention program must include the integration of resources between Indian Health Services and the Bureau of Indian Affairs (BIA).

Due to the isolation of our villages, our school has become the focus of our socialization. We can only meet at the school or at school sponsored events. Prevention would be greatly improved if the schools and the IHS coordinated prevention efforts.

As Indian youth, we, better than anyone else, know our problems and our needs. We know what services will be most effective and the methodologies which assure maximum productive results. Therefore, it is imperative that the directives of Title I, Sec. 101(b)(1) and Sec. 101(a)-(1-6) be followed.

To aid in the development and implementation of prevention programs, input should be gathered at the tribal level. A Youth Prevention Board should be a key element in such input.

The objective of all planning should be to develop a program which is culturally sensitive to individual tribes, thereby assuring the component of prevention which we have found successful -- the enhancement of positive self-esteem through increased awareness of culturally traditional belief systems.

Title II. Education

There is a great need for an increase in trained counselors if prevention efforts are to be successful. As youth, we depend on these people for information and for emotional support in times of crisis, as well as on adult sponsors for our prevention activities. These counselors, if they are not O'Odtham, should be trained in culturally sensitive methods of drug and alcohol abuse prevention.

Education. Due to the isolation of our villages, our school has become the center for our social existence. Logistically, to be effective, to reach the highest possible service area with the least amount of expense, it is essential for prevention programs to be located at our school. As an "on reservation" public school, we have been hit hard by budget cuts. In order to make prevention education a reality, additional monies are needed to develop and implement effective prevention strategies. As Native Americans, our rate of poverty, teen suicide, alcohol abuse and inhalents abuse are higher than that of all our non-Indian peers. To survive, we have only one reservoir on which to draw -- our heritage, our culture. It is the one source of inner strength and pride that is left us. Our belief systems can only be focused on preventive programs if members of our tribe participate in the planning of a prevention curriculum. Therefore, to ensure productive implementation of programs and expenditure of federal monies, it should be mandated that such prevention curriculum should be culturally sensitive and receive input from the respective tribes.

Title II. Sec. 20J (a)(1-3).

Summer recreation and counseling programs should be revised to include provisions which would ensure the individual tribes control of the development and implementation of prevention activities. Again, to be effective, to incorporate culturally sensitive needs, our youth, our adults and our elders must have a part in the decisions regarding program development and implementation, for we, the O'Odtham youth best know the needs of O'Odtham youth.

Title III. Family's and Social Services

We philosophically agree that prevention education and training is needed for all Indian peoples, the curriculum which is utilized should be culturally sensitive and meet the needs of tribal social structure.

Title IV. Law Enforcement

We recognize that shelter care units and community based treatment facilities are a good alternative to incarceration of youth for drug and alcohol abuse. However, we do not feel that the decision for such referrals, or the mechanics of operation of these facilities should be decided by non-Indians, non-tribal members. Only Indian/tribal members know what our needs as Indian youth are and what steps must be taken to aid us toward a successful and productive entry into tribal society.

Title V. Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation

Title V gives the Director of IHS powers which cannot be achieved without input from the Indian Peoples.

The study process would be most successful if the content, method, implementation and use of results were stimulated to be that of individual tribes. Again, Native Americans best know the needs of their own peoples.

As youth, we would like to state first-hand that to be placed in an off-reservation facility or a faculty whose location and operation were not decided by our adults, would be psychologically devastating. Our Community Health Board should be empowered with such responsibility. It should not rest in the hands of the Director of Indian Health Care or other non-tribal individuals or groups. To protect us, referral procedures should be the responsibility of our tribe, not the IHS Director.

We are concerned that monies which could be utilized to save the lives of our peers will instead be used to develop and pay for an administration entity; that the implementation of programs will be delayed by the institution of a survey which, in effect, will not even be assigned to competent tribal members, but to non-tribal individuals [groups].

The lives of our peers should be considered priority over any administrative considerations. The programs should be evaluated during their implementation. We already know the needs, we already know who our peers are who need prevention services. Daily, we experience the pain and grief of the destructive elements of drug, alcohol and inhalents abuse. To wait or delay direct assistance will only extend our suffering; the physical and emotional maiming and killing of our friends, siblings, parents and elders.

We wish to request the addition of inhalents abuse as a health problem among Indian youth which, to date, has not been addressed or recognized by the IHS as a health problem.

Toxic substances are more readily available to us and, therefore, become vastly used as a means of intoxication among our youth.

The use of inhalents is physically, mentally and emotionally extremely destructive. It permanently destroys brain cells, causing permanent brain damage and leading to psychological disorders and psychoses. The rate of death resulting from heart attacks and/or suffocation is high.

This practice is prevalent among Indian children as early as age 4 as well as among older children. Very few of the youth are aware of the dangers of inhalents yet. We desperately need help in this area as it is a critical health problem among Indian youth and will continue to grow unless it can be controlled -- this cannot be accomplished without funds.

Prevention efforts should encompass inhalent abuse as a widespread problem. The Indian Health Service should recognize the urgent need for assistance with inhalent abuse that is so prevalent among Indian youth.

We, as a people, face genocide if alcohol, drug and inhalent abuses continue. We, as youth, want a future; we want to live and to be productive. We need your help. Our peers listen to us -- we are a valuable prevention-intervention tool. We need financial help to accomplish our objective of wiping out drug, alcohol and inhalent abuse among the O'Odtham youth. We need monies to make a "school-based", "Students Against Drunk Driving", chapter feasible. We need monies to sponsor culturally enhancing activities for our peers. We need monies to save the lives of our peers and to help assure a chance...a future for all O'Odtham peoples.

STATEMENT OF JIM STEVENS, AREA DIRECTOR, PHOENIX AREA OFFICE, BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE HEARING OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS, HOUSE OF REPRESENTATIVES, ON H.R. 1156, THE "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT," IN PHOENIX, ARIZONA, JUNE 15, 1985.

Good morning Mr. Chairman. My name is Jim Stevens. I am the Phoenix Area Director for the Bureau of Indian Affairs. Mr. Peter Soto, the Phoenix Area Education Program Administrator, is with me today to assist in answering any questions you may have regarding our education programs. The Phoenix Area serves 47 reservations and colonies, mostly located in the three-state area of Arizona, Nevada and Utah. In Arizona, we represent all tribes except the Navajo, which has its own area office. In addition, there are two off-reservation boarding schools under the jurisdiction of the Phoenix Area -- the Phoenix Indian High School here in Phoenix and Sherman Indian High School in Riverside, California.

Indian youth represent a considerable segment of the total tribal population. According to the January, 1985, Indian Service Population and Labor Force Estimates of the Bureau of Indian Affairs, Arizona has an Indian population of nearly 166,000 on or near reservations with more than one-third under the age of 16. Utah has an Indian population of nearly 7,500, with more than 2,700 under the age of 16. In Nevada, the Indian population is 8,400 and 2,900 are under the age of 16.

I am pleased to be here today to give you an overview of the problems we are encountering with drug and alcohol abuse among our young people. I would like to talk about each of our programs separately because each one deals with the problem from a different perspective.

Education

A recent Indian Health Service (IHS) report on the conditions at Sherman Indian High School in Riverside, California stated: "The extent to which substance abuse is a major health problem is dramatically documented by the findings that such abuse is a factor in more than one-half of all clinical and behavior reports of adjustment difficulties." This study was the first step in setting into place an effective program to counter alcohol and substance abuse among students at Sherman. The study showed there are an average of 130 behavioral incidents reported at Sherman each month and the number one infraction listed was alcohol abuse.

A cooperative effort between IHS and BIA began in March, 1984. Through a series of meetings, an agreement was reached establishing a pilot project at Sherman Indian High School. The project which was titled, "To Your Health -- Living with Alcohol" provides an educational program to teach students responsibility, and highlights the potential dangers in the consumption of alcohol. It also attempts to establish its message within the context of Indian life, relationships and social structure. We are currently in the process of evaluating the success of this program.

Additional avenues of communication have been developed between BIA educators and staff from the Indian Health Service to seek other methods for dealing with the problem of alcohol and drug abuse. In the past, Phoenix Area school officials looked to the IHS only for technical assistance and health services. But that is changing. It now appears that we can and should continue the cooperative venture to seek solutions to this important problem.

The Phoenix Area schools are providing numerous programs aimed at informing students of the inherent problems associated with substance abuse. These programs include: Education and Prevention, Alcohol Prevention, Fetal Alcohol Syndrome, Alcohol Awareness Training, Native American Substance Abuse Counseling, Group-Peer Counseling and Narcotics Anonymous. The programs may use staff resources from the IHS, tribal organizations, and other governmental sources in addition to the assistance given by the Bureau of Indian Affairs.

Law Enforcement

Currently there are no special detention facilities in the Phoenix Area to specifically house juveniles arrested for alcohol and drug related crimes. Many adult facilities are used to house juveniles but in separate areas. Unfortunately, not all facilities have complete sight and sound separation between adult and juvenile inmates. However, in the past few years, the Bureau has renovated or is in the process of renovating and bringing up to Federal standards seven facilities in the Phoenix Area which include sight and sound separation requirements. Two reservations have detention facilities exclusively designed for juveniles.

Access to state facilities has been, for the most part, on a case-by-case basis. Nevada and Arizona have state attorney general opinions denying custody of Indian youth adjudicated through tribal courts.

Judicial Services

In calendar year 1984, 1404 juvenile cases went through tribal courts in the Phoenix Area on alcohol or drug related offenses. This comprised 30 percent of the total juvenile cases handled by the tribal courts.

While these cases are specifically identified as being alcohol or drug related, they may not be a true indicator of all cases in which substance abuse was involved. For example, a minor may have been charged with assault, being a runaway, or breaking and entering. While these offenses were charged, the minor may have been under the influence of alcohol or other controlled substances at the time the offense was committed.

On the other hand, these figures are not adjusted for chronic offenders. Court statistics show only the offense committed and docket number. It could be possible, therefore, that a particular juvenile is counted through the system several times, under different charges, with separate dispositions.

Some tribal courts have juvenile probation officers and counseling staff, but most professional court staff hired by a tribe service adult offenders. No probation or counseling staff is provided to a BIA Court of Indian Offenses.

Social Services

There are 28 direct service programs in the Phoenix Area two BIA operated and 26 tribally contracted. Areawide, our Social Services Program provides residential care to 34 youth, whose problems are identified, in part, as substance abuse. As young people are entering and leaving these programs, in a year's period we actually serve about twice this number. For the past two years, there have been no placements made where the Indian Health Service shared the costs of care.

In most cases where the BIA's Social Services Child Welfare Program provides cost of placement services for youth with related substance abuse problems, the primary reason for placement is not alcoholism or drug abuse. Examples would be other maladaptive behavior, such as delinquency, negative family relationships and other serious interpersonal relationship problems.

Family and group counseling services are provided by Indian Child Welfare Grant workers and BIA Social Services workers. Half of the 24 Indian Child Welfare Act (ICWA) grantees in this area attempt to reach parents by providing parent effectiveness training (which includes alcohol and drug abuse topics) to improve their parenting skills. Youth group counseling sessions are also held to assist in achieving independence and problem-solving.

This concludes my prepared statement. We will be happy to answer any questions you may have.

PHOENIX AREA DIRECTOR GEORGE BLUE SPRUCE, JR., D.D.S., A.S.G.

TESTIMONY

Juvenile Alcoholism Field Hearing

Phoenix, Arizona

June 15, 1985

Mr. Chairman, and members of the Committee:

My name is Dr. George Blue Spruce, Jr., Area Director and Assistant Surgeon General of the Phoenix Area Office of Indian Health Service. I have been asked to provide you with information regarding Indian Health Services for Indian juveniles relative to alcohol and drug abuse. I am accompanied by Ted Redding, M.D., Chief Medical Officer of the Phoenix Area Office of Indian Health Services.

Services for alcoholism and drug abuse for both the juvenile and the adult are provided primarily by 142 staff persons in 34 contractor and Indian Health Services sites in three states. Included within the above 34 programs are two directly funded Indian Health Service service units, i.e., Whiteriver and San Carlos Indian Health Service Hospitals; nine equity health care funded programs; three urban programs; and twenty tribal contract programs.

I would like to expand briefly on the above programs to indicate the range of activities underway. Since FY 1978, twenty-three programs previously supported by the National Institute of Alcohol Abuse and Alcoholism grants were transferred to the Phoenix Area Office of Indian Health Service.

The services provided by those programs included outpatient counseling, halfway house care, and limited educational services to the community. Under NIAAA alignment, most programs acted independently without serious involvement of the remainder of the health care community. Since the transfer, however, most programs have increased their involvement within the medical community in response to their mutual need for: followup on referred cases; training for contract staff; expertise in mental health consultation, health education services, and field health nursing services. This general positive trend is far from being completely realized in all IHS service unit areas. However, the best example of where it is being implemented most successfully is in the Whiteriver Service Unit.

The Whiteriver Service Unit, in response to community need, implemented a three bed detoxification unit which will be expanded to a six bed unit this fiscal year. The unit is under the supervision of a medical director and is staffed by a program coordinator and nursing staff.

On discharge from the inpatient unit, all patients discharged for alcoholism are automatically referred to the White Mountain Apache Tribal Rainbow Center for a 30 day stay in the primary residential treatment center. On discharge from the center, clients are further referred to the Apache Tribal Guidance Clinic for followup. On reactivitation of the problem, the client enters the system for another cycle. According to the First Phoenix American Corporation which had been commissioned by Indian Health Service in FY 1984 to do an independent evaluation and to develop model programs for further implementation by Indian Health Service, the health care system described is recommended as a model system. (Source: IHS Contract No. 240-083-0100, identification and assessment of model Indian Health Service alcoholism projects, June 14, 1984.)

The system works because the Whiteriver community is involved in the delivery of services. This is further evidenced by: the active participation of the health and social welfare community in the local Alcohol Task Force which meets monthly; annual health fairs featuring alcoholism program floats; radio spots; newspaper feature articles; and poster contests within the school system which have resulted in National IHS awards to school children for prevention themes.

The Alcohol Task Force includes BIA social and law enforcement personnel; IHS medical, social, psychological, nursing personnel; community treatment providers and local school principals.

With equity funding in FY 1984, an alcoholism program has also been designed and implemented for the Phoenix urban Indian community. This system again calls for the entry point at the Phoenix Indian Medical Center (for patients being discharged for alcoholism) to be referred for further care in subcontracted Indian primary residential treatment centers. It is too early to provide a further description of its effectiveness.

Two other service units - San Carlos and Colorado River - have added or are in the process of adding Indian Health Service Alcoholism Program Specialists to provide primary inpatient treatment and referral services. At the San Carlos Service Unit, the specialist is actively involved in the provision of education services within the local school systems - both public and private - and is working closely with the youth residential treatment facility staff through the use of media from Project Cork, the Seattle King County K through 12 program, the State of Arizona alcoholism curriculum, and other similar resources.

The specialist is active in the local rodeo association and supports the interest and participation of youth in this wholesome activity. The emphasis of this effort is on image change, having fun without alcohol or other drugs, and the development of a positive lifestyle.

The Phoenix Area has a contract with the Indian Alcoholism Counseling and Recovery House Program in Salt Lake City. This program is a primary residential treatment center with a capacity of 30 beds for males and 15 beds for females. Without describing these activities or the results of the program for adults, I would like to indicate that this program is a multi-service agency providing community educational services (GED and skill building services) and prevention activities for the urban Indians of Salt Lake City. Since its inception two years ago, the prevention program component has been evaluated by the State of Utah and annually received its highest rating. The program not only helps the youth with school work and provides fun activities to enhance retention in school but it also involves the parents in their need to understand what it means to be an Indian in an urban environment with values different from the mainstream. Each family completes a rigorous profile for tracking purposes and learning objectives are established which are then monitored by program personnel. Again, the keys to this successful program are dedicated staff and an involved, interested, and aggressive Board of Directors representative of the community.

I would like to now address specific service related questions and add further concerns before closing.

Estimated Youth Service Population

Based upon an estimated service population in 1980 of 74,020 and using Table 2.4 of the 1985 chart series book for Indian Health Service, the following frequency distribution is constructed for youth population defined as aged 19 and under.

Age	Percent Indian in Population*	Projection for Phoenix Area
Under 5 years	10.486	7762
5 to 9 years	10.141	7506
10 to 14 years	11.153	8255
15 to 19 years	12.215	9042

(*Source: Based on the percent distribution of the total Indian and Alaska Native population for each State in the Phoenix Area, 1980 Census Date (Arizona, California, Utah, Idaho, Nevada, Oregon).

For purposes of comparison, the following frequency distribution is constructed from data in the Alcoholism Treatment Guidance System for Phoenix Area noting admissions to contract programs for alcoholism and excluding short-term contracts.

Age	Number Youth	
	FY 83	FY 84
Under 5 years	0	1
5 to 14 years	3	2
15 to 24 years	78	97
Total	81	100
13 to 19 years	32	28

These data do not include youth at the Sherman Indian High School and the Phoenix Indian High School for whom treatment is indicated.

Estimated Cost Per Youth Treated

Based upon the evaluation of Phoenix Area programs in FY 1984, the cost per client in outpatient counseling was $851.98. The 100 youths treated in FY 1984 therefore cost a total of $85,198. As a point of comparison, in the same period, the National average cost per client treated was $1,830. Therefore, the expenditure for treatment in FY 1984 for Phoenix Area was 46.5% compared to the National sample for outpatient counseling.

Medical Procedure for Direct Care

For direct care within the Phoenix Area hospital system, there is no uniform protocol followed for the admission of any patient, whether youth or adult, for alcoholism disease. Admission in this case is highly dependent upon the sensitivity and willingness of the admitting physician to risk calling the syndrome presented, alcoholism. This is often a question of personal interpretation of medico-legal issues.

Admission to IHS contract programs is limited by staff training, willingness to comply with the extensive data requirements of the Alcoholism Treatment Guidance System, salary of personnel, hours of program operation, bed space capacity, accessibility of programs for the population, the ability to provide the treatment required by the problem, and the availability of program components required to provide a broad range of treatment.

IHS/BIA Relationship

Why! or Why Not!

In reference to alcoholism, no formal relationship, e.g., by a memorandum of agreement, exists on an Area Office level with the Bureau of Indian Affairs to define the activities of sub units, vis a vis' referrals for inpatient or outpatient treatment. Such referrals occur on the local level as a matter of daily operations whether through law enforcement, the judicial process, or social services as the need arises.

Promotion of Prevention

Alcoholism and drug abuse can only be prevented through increased efforts to provide the population better alternatives for living. This involves life choices for which an adequate information base must be presented. All contract supported activities in the Phoenix Area are now required to undertake prevention activities as a matter of normal business. This means getting information out to the people routinely rather than episodically and by supporting activities on the local level which do not involve drinking alcohol.

This is not only an Indian Health Service responsibility but is a responsibility shared by the community at large and the power structure within each community.

Research in the fetal alcohol syndrome has been going on for five years at Whiteriver, Arizona; research is underway at the Salt River Indian Community to determine unmet need and to develop remedial programs; research into the effectiveness of family treatment in a prevention program will be underway in FY 1986 in Salt Lake City; evaluation of program effectiveness has been a concern in Phoenix Area for the past three years for the purpose of improving program performance (documented studies). This is an area of continued interest in Phoenix area.

Of great importance and interest to both the Indian Health Service and the Bureau of Indian Affairs is the current effort to develop, with Congressional support, an alcoholism and drug abuse treatment unit at both the Sherman Indian High School and the Phoenix Indian High School. Until this year, $5,000 has been made available from the equity funds to support program development. The Phoenix Area Indian Health Service received $250,000 of $500,000 budgeted for implementation of major intervention programs at both the Sherman Indian High School and the Phoenix Indian High School. Congressional action in FY 1984 directed redistribution of these funds upon the closing of the Intermountain School at Brigham City, Utah. As a result, both the Phoenix Area IHS and Area BIA offices have coordinated their efforts to develop an extensive plan we believe will begin to meet the needs of students attending the Riverside and Phoenix schools.

Mr. Chairman, this concludes my opening remarks. At this time we will be happy to respond to questions.

AFFILIATION OF ARIZONA INDIAN CENTERS, INC.
2721 North Central Avenue • Suite 814
Phoenix, Arizona 85004
(602) 279-0618

June 25, 1985

The Honorable Doug Bereuter
Congress of the United States
2446 Rayburn Building
Washington, DC 20515

Dear Congressman Bereuter:

The Affiliation of Arizona Indian Centers, Inc., Board of Directors met in Flagstaff, Arizona on June 21, 1985, and requested that in response to H.R. 6196 the following comments be submitted on their behalf.

The Board of Directors of the Affiliation of Arizona Indian Centers, Inc. is appreciative of your concern and efforts to develop a proactive strategy through H.R. 6196 designed to attack a common enemy among Indian communities on and off-reservations, which kills and injures our most valuable resource - our Indian youth. Each one of us can identify a young person who as a family member, a well-known friend of the family, or a friend of one of our children was involved in an alcohol or drug-related tragedy.

Unfortunately, efforts to eliminate the abuse and use of alcohol and drugs are not adequate to meet the needs of our Indian youth. On many reservations, there is a lack of available resources to develop proactive strategies and educational programs to educate the young on the effects of drugs and alcohol. In addition, many tribes have not developed regulations regarding the use of drugs; therefore, tribal authorities and police are unaware of their role in the control of drug usage on their reservations. Unfortunately, substance abuse can continue on some reservations with little interference from local legal authorities.

Because of the constant migration of Indian families from reservation to urban areas and from urban areas back to reservations, substance abuse is prevalent among Indian youth living both on and off-reservations. The 1980 Census revealed that 63% of the total Indian population residing in the United States reside in areas outside reservations, historic areas of Oklahoma (excluding urbanized areas), Alaskan native villages and tribal trust lands. Therefore, it is of utmost importance that H.R. 6196 include services for Indian youth residing in off-reservations as well as reservation areas. It is with our concern for Indian youth that the following recommendation is made.

1. The Bill should include language that would provide funds for a tribe on a per-capita basis with a provision that their off-reservation membership be served by the funds allocated for that tribe. In most large urban centers there are Native American organizations that have the capabilities of subcontracting with tribes or the designated federal agency to service the tribal members in instances where the tribes are unable to do so.

The Bill addresses a real problem that plagues Native American people wherever they may be. There is, however, a need to address the root causes of the problem. In many Native American families a young person's only role model may be an alcoholic father, mother, sister, brother, or other close relative. Another problem is the lack of early detection of developmental problems which may negatively affect the youth's ability to learn in school. All of these problems may contribute to the problems of substance abuse. There is a critical need for legislation that addresses the problem at the community, school, family, and youth level.

H.R. 6196 provides for services to be delivered through the coordinated efforts of the Department of Health and Human Services and the Department of Interior. Mandating the Secretary of the Interior to direct all Bureau of Indian Affairs Schools to include in their curriculum a program of instruction regarding alcohol and drug abuse to students in kindergarden and grades one through twelve is of utmost importance in addressing the problem. There is a concern, however, that if all responsibility is left with these two federal agencies, certain limitations of vision, effort, and sensitivity may negatively impact any efforts to address the problems of substance abuse among our youth. Presently while these agencies carry-out their responsibilities mandated by legislation, only in rare instances do they exhibit any vision and innovation. The role of these agencies should best be left within their current mandates, while through H.R. 6196 direct funding to address Indian juvenile alcohol and drug problems and needs should be contracted directly to tribes and/or Indian organizations on and off-reservations.

In addition, the following recommendations are submitted for inclusion to H.R. 6196.

Section 2. The Affiliation is in support of the proposed establishment of an Office to have oversight responsibilities. In addition, it is recommended that Indian preference be included in the hiring of staff for the Office in order to ensure the hiring of individuals who are qualified and have the understanding for culturally empathic oversight. In the consultation process, urban, off-reservation Indian organizations should also be involved.

Section 3, page 3. In the paragraph following item (C), it is recommended that the following be inserted: "with particular regard and/or preference to enjoining of Native Americans with expertise."

Section 4, (a), page 4. It is recommended that training include the delineation of historical factors which impacted the Native Americans whereupon the problems of alcoholism became prevalent. Page 6. It is recommended that the following be added: "(D) Personnel of urban, off-reservation Indian organizations (i.e. Indian service centers)."

Section 5, page 7. In addition to item (1), the following language is recommended: "and an assessment of the real extent/impact of the alcohol and drug abuse problems of Indian youth."

Section 6, page 8. It is recommended that in addition to tribes, on and off-reservation Indian organizations be authorized to operate any program under this act.

In conclusion, because of the complexity of the problems and causes of drug and alcohol abuse among Indian youth, it is recommended that additional legislation be proposed to address the role and/or responsibilities of tribal groups and federal agencies (e.g., FBI, DEA, etc.). It was addressed early in this statement that many tribes lack codification, regulations, and perhaps jurisdiction in the area of drug enforcement. In addition, there is a need for many tribes to strengthen or clarify their codes in relation to the use of alcohol. If there are to be programs that address substance abuse, clear laws regarding the use of alcohol and drugs on reservations are a necessity for the population as well as the reservation enforcement agencies.

For your information, I have enclosed additional information relative to the unmet needs of Indian youth in Arizona's Indian communities.

Thank you for the opportunity of allowing us to share our thoughts and concerns in this very grave situation.

Sincerely,

Joy J. Hanley

Joy Hanley
Executive Director

JH/vjm

Encl.

cc: John McCain
Morris Udall
Tom Daschle

YOUTH ALCOHOLISM PREVENTION LEGISLATION

Today more Native American families reside off-reservation than on. Slightly more than one-third of the nation's 1.4 million American Indians were living on Indian lands in 1980 according to a report from the Commerce Departments' Census Bureau. This report states that 486,460 American Indians lived on reservations, tribal trust lands and the historic Indian areas of Oklahoma covered by the 1980 Census. Another 880,216 lived outside these areas including 8,023 who lived in Alaska Native Villages.

Although the Western states have the highest concentration of Indians living on reservations the Native American Urban populations have shown steady growth. Lack of employment on the reservation, education and health needs have increased the flow of Indian people into the Urban areas. Adjustment to urban living is not easy and many times intensify already existing problems. Alcoholism, family problems, lack of job skills are added to urban housing, transportation and employment difficulties.

The mobility factor has not been fully recognized in the funding of Native American programs. In order to provide a continuum of services we are recommending that consideration be given to providing mechanisms within the bill which will recognize this population, and develop a program which will stress a total service model. One example of how this may be done would be allocate to tribes on a per capita basis with provision that their off-reservation membership be served as well.

In most large urban centers there are Native American organizations that have the capabilities to sub-contract with tribes and service providers such as BIA and IHS to serve tribal members in instances where tribes are not able to do so.

Located in Phoenix, Arizona, the Phoenix Indian Center is such an agency. The Center serves a metropolitan Indian population of approximately 25,000 with a full range of social employment and legal services. Alcoholism counseling is an important part of these services. Over 300 people a year participate in individual and family counseling. In addition AA groups meet at the Center twice a week. The Alcoholism Program are state funded and are limited to individuals 18 years and older. Youth may be involved in counseling but only as a member of the family. No individual youth counseling is available under current contracts. The need is great and has been recognized by studies funded by the state. An Arizona Department of Health Services study showed that American Indians made up 25% of clients in publicly funded alcohol programs, although they made up only 6 % of population.

A study of the Arizona Recovery Centers Association found; "From the information gathered through the key informant survey the ethnic group in greatest need of services was identified as American Indians. The key informant survey also showed that youth were by far the age group in greatest need and that prevent services were shown to be the service of most need."

The same study identified reasons in declining order for not seeking alcohol services:[1] American Indians: lack of acceptance of problem, lack of culturally appropriate services, lack of past positive experience."

The Phoenix Indian Center program has been widely accepted. In addition the Center has been developing a unique counseling program call the Talking Circle. Based on traditional methods the Talking Circle is proving to be an effective means of enabling the individual and family to address problems of the modern urban society while progressing toward a positive self cultural identity. The Circle is an integral part of our alcohol, mental health family and casework counseling.

Currently funded by Human Development Services under the Administration for Children, Youth and Families the project will expire on July 1. It is an example of a successful program, effective with families and youth, capable of replication that should be funded through alcohol prevention monies for Indian Youth.

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[1] ARCA Alcohol Needs Assessment for Maricopa County ARCA 1981.